

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9229

CERTIFICATE OF DEATH

09235

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 8 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FROSTBURG,		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) GUNTER HOTEL, BOX 182		1	
3. NAME OF DECEASED (Type or Print) GEORGE H. ADAMS				4. DATE OF DEATH (Month) (Day) (Year) OCT. 9, 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH November 28, 1875	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORDERLY		10b. KIND OF BUSINESS OR INDUSTRY MEMORIAL HOSPITAL		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE ADAMS				14. MOTHER'S MAIDEN NAME EDITH GRIFFITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 213-05-7115		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 4/12x				CARDIO VASCULAR RENAL			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Disease (inemia)			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10:41, 1955, to 10:41, 1955, that I last saw the deceased alive on 10:41, 1955, and that death occurred at 11:55 A.M. from the causes and on the date stated above.							
SIGNATURE Wm. S. Williams M.D.				ADDRESS (Street, city, town, state) Cumberland, Md.			
DATE SIGNED 10-9-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-12-55		NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR DATE Oct. 11, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS	

CERTIFICATE OF DEATH

1. NAME OF DECEASED ALLEGANY		2. SEX MALE		3. AGE 6 YEARS	
4. PLACE OF BIRTH ALLEGANY		5. PLACE OF DEATH HOSPITAL		6. DATE OF DEATH DECEMBER 1, 1955	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH CHOLERA		9. MANNER OF DEATH NATURAL	
10. SIGNATURE OF PHYSICIAN J. H. HARRIS		11. SIGNATURE OF DEATH REGISTRAR J. H. HARRIS		12. SIGNATURE OF WITNESSES J. H. HARRIS	

(Faint handwritten text, possibly a signature or date)

BUREAU OF VITALS

18 1955

RECEIVED

MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C, 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9230

CERTIFICATE OF DEATH

09236

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>Life</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>519 Rose Hill Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Christina Adela Askey</u>				4. DATE OF DEATH <u>10 18 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>5-30-1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		9. AGE last birthday <u>73</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Hast</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Berg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Mary Roberts Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Left Ventricular Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease with Coronary Insufficiency</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Disease, Left Ventricular Hypertrophy</u>						10 years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/8/13</u>, 19....., to <u>10/18/55</u>, 19....., that I last saw the deceased alive on <u>10/18/55</u>, 19....., and that death occurred at <u>7:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Donald Jacobson</u>		DATE THEREOF <u>10-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumberland Md.</u>	
24. REC'D BY REGISTRAR <u>10-21-1955</u>							

10330

CERTIFICATE OF DEATH

10330

Reg. Dist. No.

Usual Residence (Name of Decedent)

Married

Age

Sex

Color

Place of Birth

Usual Residence

Cause of Death

Time of Death

Place of Death

Signature of Physician

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

BUREAU V. S.

OCT 24 1955

RECEIVED

9231

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>		<u>10 Days</u>		TOWN <u>Cumberland, Md.</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>622 Sacred Heart Hospital</u>				<u>113 Columbia Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u> (Middle) <u>Patrick</u> (Last) <u>Barnhill</u>				(Month) <u>OCTOBER</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9/10-96</u>	<u>59</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>La bor</u>		<u>Queen City Brewery</u>		<u>Shaw, W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James P. Barnhill</u>				<u>Theresa Donnelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>First WW</u>				<u>214-05-4952</u>		<u>Cumberland, Md.</u>	
				<u>Wife Ethel S. Barnhill</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
572.1 IMMEDIATE CAUSE (A)				<u>Tuberculosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<u>Diverticulitis</u>			
				<u>Coronary Heart Disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/16</u> , 19 <u>55</u> , to <u>10/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>55</u> , and that death occurred at <u>1:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Leo H. Key Jr.</u>				<u>10/27/55</u>			
M.D. <u>452 N. Centre St</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 29 1955</u>		<u>St. Mary's Cemetery</u>		<u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 28, 1955</u>		<u>White R. Kautz, M.D.</u>		<u>William H. Kight</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

10235

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

FILE NO. 10235

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. BIRTH DATE

13. BIRTH PLACE

14. PLACE OF BIRTH

15. DATE OF BIRTH

16. TIME OF BIRTH

17. CAUSE OF BIRTH

18. SEX

19. AGE

20. OCCUPATION

21. MARITAL STATUS

22. EDUCATION

23. RELIGION

24. BIRTH DATE

25. BIRTH PLACE

26. PLACE OF BIRTH

27. DATE OF BIRTH

28. TIME OF BIRTH

29. CAUSE OF BIRTH

30. SEX

31. AGE

32. OCCUPATION

33. MARITAL STATUS

34. EDUCATION

35. RELIGION

36. BIRTH DATE

37. BIRTH PLACE

38. PLACE OF BIRTH

39. DATE OF BIRTH

40. TIME OF BIRTH

41. CAUSE OF BIRTH

42. SEX

43. AGE

44. OCCUPATION

45. MARITAL STATUS

46. EDUCATION

47. RELIGION

48. BIRTH DATE

49. BIRTH PLACE

50. PLACE OF BIRTH

51. DATE OF BIRTH

52. TIME OF BIRTH

53. CAUSE OF BIRTH

54. SEX

55. AGE

56. OCCUPATION

57. MARITAL STATUS

58. EDUCATION

59. RELIGION

60. BIRTH DATE

61. BIRTH PLACE

62. PLACE OF BIRTH

63. DATE OF BIRTH

64. TIME OF BIRTH

65. CAUSE OF BIRTH

66. SEX

67. AGE

68. OCCUPATION

69. MARITAL STATUS

70. EDUCATION

71. RELIGION

72. BIRTH DATE

73. BIRTH PLACE

74. PLACE OF BIRTH

75. DATE OF BIRTH

76. TIME OF BIRTH

77. CAUSE OF BIRTH

78. SEX

79. AGE

80. OCCUPATION

81. MARITAL STATUS

82. EDUCATION

83. RELIGION

84. BIRTH DATE

85. BIRTH PLACE

86. PLACE OF BIRTH

BUREAU V. S.

NOV 1 1955

RECEIVED

200000000000

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-1-83 BY 60322 UCBAW/STP

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09238

9232

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u> <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>943 Glenwood St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOSEPH BENJAMIN BATES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 22</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 18, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transfer Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Bates</u>				14. MOTHER'S MAIDEN NAME <u>Emily King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-08-8007</u>		17. INFORMANT & ADDRESS <u>Mrs Lucy Bates Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 21</u> , 19 <u>55</u> , to <u>Oct 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 21</u> , 19 <u>55</u> , and that death occurred at <u>12:07 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Quentin Humeck</u>				ADDRESS (Street, city, town, state) <u>M.D. 133 Virginia Ave, Cumberland, Md.</u>		DATE SIGNED <u>Oct 24, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Oct 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

Case No. 100

ST. MARY'S HOSPITAL, BALTIMORE, MD.

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

BUREAU V. 1

OCT 26 1933

RECEIVED
OCT 21 1933
ST. MARY'S HOSPITAL
BALTIMORE, MD.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

9233

CERTIFICATE OF DEATH

09239

Reg. Dist. No. 4

Item 7: Film G188 10/24/55 L

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		23 1/2 hrs		TOWN NEAR CUMBERLAND		rural X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
62 SACRED HEART HOSPITAL				20 VALLEY VIEW DRIVE		R.F.D. #5	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ORD MASON BELL				10-7-55 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	9-16-13	42 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SPINNER				JAPANESE CORP. OF AMERICA		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HARRY BELL				ALICE MASON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No				214-37-6103		CHART	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
455X IMMEDIATE CAUSE (A) Pulmonary Embolism				One day			
ANTECEDENT CAUSE(S) DUE TO (B) Phlebitis Septicemia Rt (Calf) leg				Two days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gangrenous toe (Traumatic) Rt 4th				24 days			
1936.01							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		Gangrenous Rt 4th toe					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		Home		Cumberland		alleg md.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
9-13-55 3 M.				Struck toe on Bed.		01	
22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 10-7-55, 19, and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
J. M. Merman M.D.				10-8-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 10, 1955		Philos Cemetery		Westernport, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 10, 1955		Winter R. Frank, M.D.		Boals Funeral, Westernport, Md.			

09240

9234

CERTIFICATE OF DEATH

DR. JACOBSON

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		3 DAYS		Near CUMBERLAND, Rural		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
60 MEMORIAL HOSPITAL				ROUTE #1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MILDRED		(Middle) C.		(Last) BLOCHER		(Month) (Day) (Year)	
						19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOW	MARCH 14, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		Own Home		INDIANA, Crawfordsville		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM ELLIOTT				ISABELLE CARL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		None		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
430.1 IMMEDIATE CAUSE (A) Cerebral vascular Accident (Embolus)						4 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						??	
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) Auricular Fibrillation							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
Coronary Artery Disease, Myocardial Disease, Coronary Insufficiency							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 28, 1955, to Oct. 1, 1955, that I last saw the deceased alive on Sept. 30, 1955, and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
James Jacobson				M.D. 50 Pershing St. Cumberland, Md		10/1/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 3, 1955		Hillcrest Bur. Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct. 1, 1955		Winter L. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

4 1955

RECEIVED

9235

CERTIFICATE OF DEATH

09241

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		1 DAY		TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
60 MEMORIAL HOSPITAL MEMORIAL AVE.				916 BEDFORD STREET		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CHARLES (Middle) S. (Last) BRANT				(Month) OCTOBER (Day) 15, (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JULY 8 1879	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Clerk		Hardware Store		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM B. BRANT				SARAH SHIELDS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		214-05-5433		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 443X Hypertensive Cardiac						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Vascular Disease						years.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Lymphatic Leukemia							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-5, 1951, to 10-15, 1955, that I last saw the deceased alive on 10-12, 1955, and that death occurred at 5:25A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
W. J. Williams M.D. Cumberland Md.						10-15-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Oct 17 1955		Hillcrest Burial Park		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 16, 1955		Walter R. Frantz, M.D.		J. H. Wright		Cumberland, Md.	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

9235

Reg. Dist. No.

1. CAUSE OF DEATH (To be filled in by physician)

2. PLACE OF DEATH
 COUNTY: **ALLEGANY**
 CITY/TOWNSHIP: **CHANDLER**
 STREET: **216 BEDFORD STREET**

3. DATE OF DEATH
 DAY: **1**
 MONTH: **OCTOBER**
 YEAR: **1925**

4. DEATH CERTIFICATE NO. **9235**
 5. SEX: **MALE**
 6. RACE: **WHITE**
 7. AGE: **2**
 8. OCCUPATION: **CHANDLER**

9. DATE OF BIRTH: **OCTOBER 17, 1923**

10. PLACE OF BIRTH: **MARYLAND**

11. SEX: **MALE**

12. RACE: **WHITE**

13. NAME OF DECEASED: **SARA B. BROWN**

14. NAME OF DECEASED: **WILLIAM B. BROWN**

15. NAME OF DECEASED: **RENEE HOSPITAL, CHANDLER, MD.**

16. NAME OF DECEASED: **RENEE HOSPITAL, CHANDLER, MD.**

Handwritten signature: W. B. Brown

Handwritten signature: G. B. Brown

BUREAU V. 2

OCT 18 1925

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician attending the deceased, or by the coroner, or by the registrar of the vital statistics, or by the health officer of the city or town, or by the health officer of the county, or by the health officer of the State.

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY		Allegany		MARYLAND	
CITY	(If outside corporate limits, write RURAL			LENGTH OF STAY	
OR	and give nearest town)			(in this place)	
TOWN	Cumberland			10/23/54	
HOSPITAL OR INSTITUTE OR STREET ADDRESS					
Allegany County Infirmary					

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Cumberland
STREET
ADDRESS 414 Hill Street (If rural give location)

3. NAME OF DECEASED
(Type or Print)

(First)	(Middle)	(Last)
Viletta	I.	Brant

4. DATE (Month) (Day) (Year)

OF DEATH October 16, 1955

5. SEX Female	6. COLOR OR FACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 4/19/1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Pitzer	Jane Rebecca Byroad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No (If Yes, give war or dates of service)	None	Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A)
 ANTECEDENT CAUSE(S) DUE TO
 DISEASES OR CONDITIONS, IF ANY, (B)
 GIVING RISE TO THE ABOVE CAUSE DUE TO
 STATING UNDERLYING CAUSE LAST. (C)

18. MEDICAL CERTIFICATION

Pulmonary Hypostasis.
Coronary sclerosis, -
Chronic Myocarditis.
Peripheral arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

4 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
------------------------	----------------------------------

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County)	(State)
--	---	---	----------	---------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Oct. 23, 1954, to Oct. 16, 1955, that I last saw the deceased alive on Oct. 15, 1955, and that death occurred at 4:25 P.M. from the causes and on the date stated above.

SIGNATURE**ADDRESS** (Street, city, town, state)

DATE SIGNED _____

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Oct. 19, 1955	NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery	LOCATION (City, town, or county) Cumberland, Md.	(State)
---	-------------------------------	---	---	---------

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <i>Oct. 18, 1955</i>	<i>Winters R. Frank, M.D.</i>	<i>Wm. H. Kight, Cumberland, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1245501

2000 年 12 月 15 日

Cont.

•

202/01

• • •

Lactuca

BUREAU V. S.

5568 8 1300

RECEIVED

Outside of
City Limits

9287

09243

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural</u> <u>LaVale</u>				TOWN <u>Grantsville</u> <u>11x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway Route #40</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. #1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Samuel</u> <u>Jonas</u> <u>Brenneman</u>				<u>Oct.</u> <u>19</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Dec. 31-1925</u>	
9. AGE Last birthday: <u>29</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Tractor-driver-self employed.</u>		11. BIRTHPLACE (State or foreign country): <u>Bittenger, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Earnest Brenneman</u>				14. MOTHER'S MAIDEN NAME: <u>Amelia Schrock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>208-16-3835</u>			
				17. INFORMANT & ADDRESS: <u>wife) Virginia Brenneman, Grantsville, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>816X</u> Immediate cause (a) <u>Intracranial hemorrhage</u> DUE TO (b) <u>Crushed skull.</u> Antecedent cause(s) (c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Crushed skull.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, bldg. etc., INJURY <u>Highway 40</u>		21c. (City or town) (County) (State) <u>LaVale</u> <u>Allegany</u> <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 19-1955</u> A.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Run-a-way Tractor trailer hit his truck, thrown out.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct. 19-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>10/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>SPRINGS</u>	
LOCATION (City, town, or county) (State) <u>SPRINGS SOMERSET Co, PA</u>		24. FUNERAL DIRECTOR <u>Ronald J. Newman</u> ADDRESS <u>Grantsville, Md</u>			

MARGIN RESERVED FOR BINDING

I

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 21 1955

RECEIVED

1 With In Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09244

9237

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		35 days		TOWN <u>McCoole</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Sacred Heart Hospital		MAILING ADDRESS		(If rural give location)	
62				Route #3, Box 7, Keyser, W. Va.		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Charles (Middle) E. (Last) Brown				(Month) 10 (Day) 1 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	6/29/02	53 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Trainman		B. & O. R. R.		Pennsylvania		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harvey Brown				Ella Huffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		(If Yes, give war or dates of service) 705-07-9746		Pt's Chart.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						35 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO						Chronic Diffuse Glomerulonephritis	
(C)						5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Hypertensive Heart Disease	
19a. DATE OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 27, 1955, to Oct 1, 1955, that I last saw the deceased alive on 10/1, 1955, and that death occurred at 7:28 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
H. Eversman M.D.				M.D. 59 Greene St Cumberland Md		10/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		10/4/55		Queens Point Cemetery		Keyser, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 3, 1955		Walter R. Frank, M.D.		B. W. Markum		Keyser, W. Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Journal of Management Inquiry 22(1)

OCT 4 1955

07 4172

9288

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY OR TOWN <u>Cresaptown</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Cresaptown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Winchester Road</u>				STREET ADDRESS <u>Winchester Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN WEBSTER CHANEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 21, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 18, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired trucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking & hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Mineral Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Chaney</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Berry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Ellis Warnick Rawlings, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arricular Fibrillation</u>				<u>6 wks.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary arterio-sclerosis</u>				<u>10 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April, 1951</u> , to <u>Oct. 1955</u> , that I last saw the deceased alive on <u>Oct 4, 1955</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. R. Brown, M.D.</u>				ADDRESS (Street, city, town, state) <u>Fort Ashby, W. Va.</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		April 22, 1928		Jackson, Mississippi	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
April 4, 1968		Memphis, Tennessee		Coronary Atherosclerosis		Natural		[Signature]		[Signature]	

Coronary Heart Failure
Arrhythmia Fibrillation
Coronary Atherosclerosis
Death

BUREAU A. 8

OCT 28 1965

F. R. Brown, M.D.
 Oct 4 22
 Fort Supply, W. Va.
 Oct 21 22
 10/24/68

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09246

9238

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		8/6/55		TOWN Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Allegany County Infirmary				123 Polk Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Edward (Middle) Martin (Last) Cheuvront				(Month) October (Day) 1 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	8/18/1870	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired - B. & O. Pipefitter					West Virginia		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Theodore Cheuvront				Phoebe Hollis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Allegany County Infirmary Records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Coronary Sclerosis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Cerebral arteriosclerosis			
				chronic Nephritis			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 6 , 19 55 , to Oct 1 , 19 55 , that I last saw the deceased alive on Oct 1st 19 55 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
James E. McLean M.D.				49 Green St			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				Oct. 4, 1955		Rose Hill Cemetery	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
Oct. 3, 1955				Walter L. Frantz, M.D.		Louis Stein, Inc.	
						Cumberland, Md.	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

2838

1. Name of deceased Theodore G. Goussard		2. Sex Male	
3. Date of birth 1914		4. Age 41	
5. Place of birth New York City		6. Race White	
7. Usual residence 123 York Street Baltimore, Md.		8. Cause of death Heart Disease	
9. Date of death October 4, 1955		10. Place of death Home	
11. Signature of physician [Signature]		12. Signature of registrar [Signature]	

BUREAU V. 2

OCT 4 1955

RECEIVED

1. Within corporate limits

09247

9239

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland, Md.</u>		<u>1 day</u>		TOWN <u>Cumberland,</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Vocke Drive, Rt. 5.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Eleanor Chorpennning</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 20 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>12/ 22/ 88</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Decker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Becker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. A. J. Chorpennning Rt. #5 Cumb. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442X Premie Poisoning</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 da.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-vascular</u>				<u>renal disease</u> <u>5 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Secondary anemia severe</u>				<u>3 mo.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebrovascular disease & the liver & hypoproteinemia</u>				<u>3 mo.</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>July 24, 19 53</u> , to <u>Oct 20, 19 55</u> , that I last saw the deceased alive on <u>Oct 20, 19 55</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. E. Hallenar MD</u>		ADDRESS (Street, city, town, state) <u>146 Bedford St. Cumberland, Md.</u>		DATE SIGNED <u>10/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Pauls</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 24, 19 55</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>			

1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09248

9240

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
02 TOWN <u>Cumberland</u>		75 years		02 STREET ADDRESS		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				(If rural give location)			
00 414. Magruder Street				414. Magruder Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u>		(Middle)		(Last) <u>Cook</u>		(Month) (Day) (Year)	
5. SEX		6. COLOR OR RACE		8. DATE OF BIRTH		9. AGE last birthday	
Female		White		Jan 2 1872		83 yrs.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		Widow		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
				House Wife		Own House	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Baltimore, Maryland				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Stuiber				Wilhemina Geseke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
William L. Cook, Cumberland, Md.				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				32 wks.			
422.2 IMMEDIATE CAUSE (A) <u>Haemnia</u>				15 yr			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.		M.					
22. I hereby certify that I attended the deceased from <u>Jan 19 40</u> , to <u>Oct 14 19 53</u> , that I last saw the deceased alive on <u>Oct 13 19 53</u> , and that death occurred at <u>3 50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Clay E. Lurrett</u> M.D.				<u>Cumberland - Md</u>			
DATE SIGNED				<u>10/15/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct 17 1955		Hillcrest Burial Park		Cumberland, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 16, 1955</u>		<u>Walter R. Grant, M.D.</u>		<u>John H. Light</u>		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

9210

Ref. Date 1955

1. NAME OF DEATH

ALLISON

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

SEX

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

IN MEDICAL CERTIFICATION

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 2

OCT 18 1955

RECEIVED

RECEIVED

1. NAME OF DEATH
2. DATE OF BIRTH
3. PLACE OF BIRTH
4. DATE OF DEATH
5. PLACE OF DEATH
6. SEX
7. CAUSE OF DEATH
8. DATE OF DEATH
9. DATE OF DEATH
10. DATE OF DEATH
11. DATE OF DEATH
12. DATE OF DEATH
13. DATE OF DEATH
14. DATE OF DEATH
15. DATE OF DEATH
16. DATE OF DEATH
17. DATE OF DEATH
18. DATE OF DEATH
19. DATE OF DEATH
20. DATE OF DEATH
21. DATE OF DEATH
22. DATE OF DEATH
23. DATE OF DEATH
24. DATE OF DEATH
25. DATE OF DEATH
26. DATE OF DEATH
27. DATE OF DEATH
28. DATE OF DEATH
29. DATE OF DEATH
30. DATE OF DEATH
31. DATE OF DEATH
32. DATE OF DEATH
33. DATE OF DEATH
34. DATE OF DEATH
35. DATE OF DEATH
36. DATE OF DEATH
37. DATE OF DEATH
38. DATE OF DEATH
39. DATE OF DEATH
40. DATE OF DEATH
41. DATE OF DEATH
42. DATE OF DEATH
43. DATE OF DEATH
44. DATE OF DEATH
45. DATE OF DEATH
46. DATE OF DEATH
47. DATE OF DEATH
48. DATE OF DEATH
49. DATE OF DEATH
50. DATE OF DEATH
51. DATE OF DEATH
52. DATE OF DEATH
53. DATE OF DEATH
54. DATE OF DEATH
55. DATE OF DEATH
56. DATE OF DEATH
57. DATE OF DEATH
58. DATE OF DEATH
59. DATE OF DEATH
60. DATE OF DEATH
61. DATE OF DEATH
62. DATE OF DEATH
63. DATE OF DEATH
64. DATE OF DEATH
65. DATE OF DEATH
66. DATE OF DEATH
67. DATE OF DEATH
68. DATE OF DEATH
69. DATE OF DEATH
70. DATE OF DEATH
71. DATE OF DEATH
72. DATE OF DEATH
73. DATE OF DEATH
74. DATE OF DEATH
75. DATE OF DEATH
76. DATE OF DEATH
77. DATE OF DEATH
78. DATE OF DEATH
79. DATE OF DEATH
80. DATE OF DEATH
81. DATE OF DEATH
82. DATE OF DEATH
83. DATE OF DEATH
84. DATE OF DEATH
85. DATE OF DEATH
86. DATE OF DEATH
87. DATE OF DEATH
88. DATE OF DEATH
89. DATE OF DEATH
90. DATE OF DEATH
91. DATE OF DEATH
92. DATE OF DEATH
93. DATE OF DEATH
94. DATE OF DEATH
95. DATE OF DEATH
96. DATE OF DEATH
97. DATE OF DEATH
98. DATE OF DEATH
99. DATE OF DEATH
100. DATE OF DEATH

09249

9241

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY		STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		LENGTH OF STAY (In this place) 14 HOURS		CITY (If outside corporate limits, write RURAL and give nearest town) KEYSER DANVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) KEYSER DANVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.		STREET ADDRESS (Mailing address) RT. #3, BOX 163, Keyser, West Virginia.		STREET ADDRESS (Mailing address) RT. #3, BOX 163, Keyser, West Virginia.		STREET ADDRESS (Mailing address) RT. #3, BOX 163, Keyser, West Virginia.	
3. NAME OF DECEASED (First) (Middle) (Last) BERTHA A DAVIS				4. DATE OF DEATH (Month) (Day) (Year) OCT. 26 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPT. 18, 1892	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if part time) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE LUZIER				14. MOTHER'S MAIDEN NAME SARAH PASE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) MASSIVE CEREBRAL HEMORRHAGE				MASSIVE CEREBRAL HEMORRHAGE		20 hr.	
ANTECEDENT CAUSE(S) DUE TO (B) HYPERTENSION				HYPERTENSION		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 15, 1955, to Dec. 26, 1955, that I last saw the deceased alive on Dec. 26, 1955, and that death occurred at 10:25 AM from the causes and on the date stated above.							
SIGNATURE <i>Clayton J. Lurvey</i> M. D.				DATE SIGNED <i>Cumberland</i> 10/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF Oct. 29, 1955		NAME OF CEMETERY OR CREMATORY Dawson Cemetery		LOCATION (City, town, or county) (State) Dawson, Maryland.	
24. REC'D BY REGISTRAR Oct. 29, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Brantley, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Rogers Funeral Home</i>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9277

CERTIFICATE OF DEATH

09250

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL or end, give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>WESTERNPORT</u>				TOWN <u>WESTERNPORT</u>		43	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>167 Church ST</u>				STREET ADDRESS (If rural give location) <u>167 Church ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>DeSales</u> (Last) <u>Dempsey</u>				(Month) <u>Oct</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>16 April 1904</u>	<u>51</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Machine Operator Paper Mill</u>		<u></u>		<u>BARTON, Md</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>James Dempsey</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. Broderick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>217-05-0578</u>		<u>Mrs Rose Dempsey, 167 Church ST, WESTERNPORT</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>430.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 Days</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Arterial Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Sept 27, 1955</u> , to <u>Oct 10, 1955</u> , that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul B. Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont W.V.</u>		DATE SIGNED <u>Oct 11, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. GABRIEL'S Cem</u>		LOCATION (City, town, or county) <u>WESTERNPORT Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Bival</u>		ADDRESS <u>WESTERNPORT, MD</u>	
DATE <u>10-11-55</u>							

CERTIFICATE OF DEATH

1937

2-3-011-111

DEATH CERTIFICATE OF DEATH

DEATH CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. R.

1937

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09251
Reg. Dist.

No. 410

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Barrelsville</u>		<u>30 years</u>		TOWN <u>Barrelsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural, give location) <u>Home</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Fred Washington Elfritz</u>				<u>Oct. 21 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>widower</u>	<u>Sept. 26-1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>		<u>Construction work</u>		<u>Cabin Run, W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Isiah Elfritz</u>				<u>Marjorie Marpole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>1919</u>		<u>(son) Arthur Elfritz, Barrelsville, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> Immediate cause (a) <u>Myocardial failure</u> DUE TO						<u>Gradual</u>	
Antecedent cause(s) (b) <u>Chronic myocarditis also had arteriosclerosis</u> DUE TO <u>and paralysis of right side of body due</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE stating underlying cause last (c) <u>to apoplexy five years ago.</u>						<u>several years.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>H. V. Deming M.D.</u>				<u>Oct. 22-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 24, 1955</u>		<u>Cook's Cemetery</u>		<u>Barrelsville, Penna.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 24, 1955</u>		<u>Terence Mc Dermott</u>		<u>John J. Hoyer, Cumberland, Md.</u>			

BUREAU V. S.

OCT 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md. COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN Cumberland	2 yrs		TOWN Cumberland	02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Dead on arrival at the Sacred Heart Hospital.		STREET ADDRESS	(If rural, give location) 232 N. Mechanic St. 1	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Rose	Mae	Emerick	Oct.	10 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
female	white	Married	Dec. 13-1917	37 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife	Clean Home	Cumberland, Md.		U.S.A.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Charles W. Cross			Bessie M. Free		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
no		none	(husband) Wm. E. Emerick, Cumberland, Md.		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... Coronary Occlusion DUE TO Antecedent cause(s) (b)..... Coronary sclerosis. Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....				sudden ?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> Oct. 10-1955					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		Oct. 13, 1955		Hillcrest Burial Park Cumberland, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Oct. 13, 1955		Winters R. Thawley, M.D.		John J. Hafer, Cumberland, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 17 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9290

CERTIFICATE OF DEATH

09253

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Midland				TOWN Midland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise Street				STREET ADDRESS (If rural give location) Paradise			
3. NAME OF DECEASED (Type or Print) JANE FAIR				4. DATE OF DEATH (Month) (Day) (Year) 10/27/55			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH May, 26th, 1882	
				9. AGE last birthday 73 yrs.		10. IF UNDER 1 YEAR Months Days 19 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mt. Savage, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Ready				14. MOTHER'S MAIDEN NAME Ann Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS James Fair (SON)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Midland, MD.		INTERVAL BETWEEN ONSET AND DEATH 29	
190X IMMEDIATE CAUSE (A) Melanocarcinoma of Breast							
ANTECEDENT CAUSE(S) DUE TO (B) 2 chest & generalized metastases							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION Sept 1954		19b. MAJOR FINDINGS OF OPERATION Melanocarcinoma		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 27 , to 29 Oct , 19 55 , that I last saw the deceased alive on 29 Oct , 19 55 , and that death occurred at 5:50 P. M, from the causes and on the date stated above.							
SIGNATURE George Richardson M.D.				ADDRESS (Street, city, town, state) Lonaconing Md		DATE SIGNED 10-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 31st, 1955		NAME OF CEMETERY OR CREMATORY Belvedere Cemetery, Midland, MD.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Jeanette M. Pool		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		ADDRESS	
DATE 10-31-55							

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or the State Department of Health. It is a legal document and its contents are subject to review by the authorities.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1955

Form 10-1-55

1. Name of deceased

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

BUREAU A. 2

1955

RECEIVED

John Doe

John Doe

Outside of
City Limits

9291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

09254

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Rural LaVale</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Frostburg</u>	<u>22</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway-Route 40</u>		STREET ADDRESS (If rural, give location) <u>2 Mt. Pleasant St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Clifford Playford Fearer</u>		4. DATE OF DEATH <u>Oct. 19</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>April 23-1916</u>
9. AGE last birthday: <u>39</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Westernport, Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Leslie Fearer</u>		14. MOTHER'S MAIDEN NAME: <u>Jennie Laird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W.2</u>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>(wife) Willa Fearer, Frostburg, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
816X Immediate cause (a) <u>Intracranial hemorrhage due to a crushed skull.</u>		DUE TO chest.	sudden
Antecedent cause(s) (b) <u>Intrathoracic hemorrhage due to a crushed chest.</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>3rd. & 4th. degree also had burns of head, face & back of shoulders</u>			

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Injury Highway 40</u>	21c. (City or town) <u>LaVale</u> (County) <u>Allegany</u> (State) <u>Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 19/55 A. M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>Run-a-way Tractor trailer ran in automobile.</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED Oct. 19-1955
M. D. DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Oct. 22, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Michael's Cemetery, Frostburg, Maryland</u>	LOCATION (City, town, or county) (State): <u>Frostburg, Md.</u>
DATE REC'D BY LOCAL REG. <u>Oct. 20, 1955</u>	REGISTRAR'S SIGNATURE: <u>Winters R. Thaw, M.D.</u>	24. FUNERAL DIRECTOR: <u>Kaiser Funeral Home, Frostburg, Md.</u>	ADDRESS: <u>Winters R. Thaw, M.D.</u>

BUREAU V. S.

OCT 21 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09255

9278

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Westernport</u>		<u>30 yrs</u>		TOWN <u>Westernport</u>		<u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 Wood ST</u>				STREET ADDRESS (If rural give location) <u>210 Wood ST</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles William Feight</u>				<u>Oct 9 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb 9, 1880</u>		<u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Carpenter-Pkt. Paper mill</u>			<u>Schellburg, Pa</u>		<u>U. S.</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Andrew J. Feight</u>				<u>Sarah Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>212-09-5585A</u>		<u>Mrs Mary Feight</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Cerebral Hemorrhage.,</u>						<u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)						<u>2 yrs</u>	
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 2</u> , 19 <u>55</u> , to <u>Oct 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>55</u> , and that death occurred at <u>12:30 a</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>[Signature]</u>				<u>Piedmont W Va.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-12-55</u>		<u>MT Oliver Cem.</u>		<u>Marys Choice, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 10-11-55</u>		<u>Mrs Jean C Kelly</u>		<u>E. B. B...</u>		<u>Westernport, Md.</u>	

100355

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

00378

Spec. Form 100-100

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. CAUSE OF DEATH

5. PLACE OF BIRTH

6. SEX

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. HUSBAND'S NAME

12. FATHER'S NAME

13. MOTHER'S NAME

14. DATE OF BIRTH

15. DATE OF DEATH

16. DATE OF BURIAL

17. DATE OF CREMATION

18. SIGNATURE OF DECEASED

1955

RECEIVED

100355

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9279

09256

Reg. Dist. 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>22 TOWN Frostburg</u>				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Eckhart Mines</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>B.F.D. #1 Frostburg, Md.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Alice</u>		(Middle) <u>Elker</u>		(Last) <u>Elker</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>April 2-1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>48</u> yrs.		4. DATE OF DEATH: (Month) <u>Oct.</u> (Day) <u>29</u> (Year) <u>1955</u>	
11. BIRTHPLACE (State or foreign country): <u>Connelsville, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Clarence Graves</u>				14. MOTHER'S MAIDEN NAME: <u>Lura Logue</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Miners Hospital records.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>584X</u> Immediate cause (a) <u>Chronic glomeruli nephritis also had</u> DUE TO <u>Cardio hypertrophy</u> Antecedent cause(s) (b) <u>Atelectasis of both lungs</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Subacute cholecystitis with cholelithiasis.</u>						<u>?</u> <u>acute</u> <u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Died under an anaesthetic.</u>						<u>55</u>	
19a. DATE OF OPERATION: <u>Oct. 29-1955</u>						19b. MAJOR FINDING OF OPERATION: <u>cholelithiasis</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>M.D.</u>		<u>Oct. 29/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>11-1-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Eckhart</u>		LOCATION (City, town, or county) (State): <u>Eckhart Maryland</u>	
DATE REC'D BY LOCAL REG. <u>10-31-55</u>		REGISTRAR'S SIGNATURE: <u>Wm. Harvey H. Roe</u>		24. FUNERAL DIRECTOR: <u>John L. Hurst</u>		ADDRESS: <u>Frostburg, Md.</u>	

BUREAU V. S.

NOV 2 1955

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09257

9243

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>6/26/53</u>		TOWN <u>Cumberland</u>		STREET ADDRESS (If rural give location) <u>Braddock Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>				STREET ADDRESS <u>Braddock Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Florence Gertrude Fisher</u>				<u>October 4, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>9/15/1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Charles A. Hammer</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hackley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-0688</u>		17. INFORMANT & ADDRESS <u>Allegany County Infirmary Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>24 hrs</u>			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				<u>72 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebral Arteriosclerosis</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>				<u>?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1953</u> to <u>Oct. 4, 1955</u> , that I last saw the deceased alive on <u>Oct. 3, 1955</u> , and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. McLean</u> M.D.				DATE SIGNED <u>10/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Prosperity Cem.</u>		LOCATION (City, town, or county) <u>Near Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

1. Within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9244

CERTIFICATE OF DEATH

09258

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY 39 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 206 COLUMBIA STREET 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MYRTLE		(Middle) A		(Last) FISHER		DATE OF DEATH OCT. 9 19 55	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH MARCH 25, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper at Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAXX QUILLAN SELLER				14. MOTHER'S MAIDEN NAME REBECCA MOWER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL-CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 331X Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO Arterio Sclerotic Vascular							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Disease							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8:31, 19 55, to 10:41, 19 55, that I last saw the deceased alive on 10:41, 19 55, and that death occurred at 11:15 PM, from the causes and on the date stated above.							
SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city, town, state) Cumberland Md			
DATE 10/11/55				DATE SIGNED 10/11/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/12/55		NAME OF CEMETERY OR CREMATORY Bedford Cemetery		LOCATION (City, town, or county) Bedford, Penna.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
10/11/55		Walter R. Huntz M.D.		H. Lee Silcox		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1 Within corporate limits

9245

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		5 DAYS		TOWN FRIENDSVILLE		11X-2	
60 HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) MARY (First) V. (Middle) FRAZEE (Last)				4. DATE OF DEATH (Month) (Day) (Year) OCT. 26- 19 55			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH 1905 JULY 14, 1904	
						9. AGE last birthday 50 3/4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. K. LIVINGOOD,				14. MOTHER'S MAIDEN NAME ZORRIE FEATHERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Hypertension and arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Heart disease with congestive failure							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) failure				6 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12 Sept., 19 55, to 26 Oct., 19 55, that I last saw the deceased alive on 26 Oct., 19 55, and that death occurred at 10:07 P.M. from the causes and on the date stated above.							
SIGNATURE W. A. Van Orman M.D. County Health Officer				ADDRESS (Street, city, town, state) 27 West 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/29/55		NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		LOCATION (City, town, or county) Near Friendsville, Md.	
24. REC'D BY REGISTRAR Dek. 29, 1955		REGISTRAR'S SIGNATURE Winters R. Brantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE H.L. Browning		ADDRESS Kingwood, W. Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1915

NAME

LAST FIRST MIDDLE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

STATE OF MARYLAND
COUNTY OF BALTIMORE

BUREAU A. 2

RECEIVED

9246

CERTIFICATE OF DEATH

09260

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN CUMBERLAND		3 HRS. 20 MIN		TOWN CUMBERLAND,		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 230 CECILIA STREET (If rural, give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ANNA FRETWELL				10 1 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	MAY 2 1879	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Ownhome		WEST VIRGINIA		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Patrick Burke				Nora Samon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		None		MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)						8 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 10/15/53, 19, to 10/1/55, 19, that I last saw the deceased alive on 10/1/55 19, and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
J. Williams		10-4-55		St. Mary's Cemetery		Cumberland, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
burial		WRITER R. Hantz, M.D.		James F. Scarfelli		James F. Scarfelli, Cumberland, Md.	

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased and is to be submitted to the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Maryland.

2. The information furnished on this form is for statistical purposes only and is not to be used for any other purpose.

3. The information furnished on this form is to be confidential and is not to be disclosed to any other person.

4. The information furnished on this form is to be used for the purpose of determining the cause of death and for the purpose of determining the place of death.

5. The information furnished on this form is to be used for the purpose of determining the date of death and for the purpose of determining the time of death.

6. The information furnished on this form is to be used for the purpose of determining the sex of the deceased and for the purpose of determining the race of the deceased.

7. The information furnished on this form is to be used for the purpose of determining the age of the deceased and for the purpose of determining the marital status of the deceased.

8. The information furnished on this form is to be used for the purpose of determining the occupation of the deceased and for the purpose of determining the education of the deceased.

9. The information furnished on this form is to be used for the purpose of determining the cause of death and for the purpose of determining the place of death.

10. The information furnished on this form is to be used for the purpose of determining the date of death and for the purpose of determining the time of death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1955

1. NAME OF DECEASED ALBERTA GUMERMAN		2. SEX F		3. AGE 38.5		4. DATE OF BIRTH JAN 15 1917		5. PLACE OF BIRTH NEW YORK	
6. MARITAL STATUS MARRIED		7. OCCUPATION HOUSEWIFE		8. EDUCATION HIGH SCHOOL		9. RACE WHITE		10. RELIGION METHODIST	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME		13. DATE OF DEATH OCT 5 1955		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN J. H. HARRIS	
16. SIGNATURE OF DECEASED ALBERTA GUMERMAN		17. SIGNATURE OF WITNESS J. H. HARRIS		18. SIGNATURE OF DECEASED ALBERTA GUMERMAN		19. SIGNATURE OF WITNESS J. H. HARRIS		20. SIGNATURE OF DECEASED ALBERTA GUMERMAN	

BUREAU V. A.

OCT 5 1955

RECEIVED

3292

09261

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Rural Cumberland</u>		LENGTH OF STAY (in this place) <u>16 yrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland (rural)</u> <u>X</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#5, Winchester Road</u>			STREET ADDRESS (If rural, give location) <u>R.F.D.#5, Winchester Road</u>		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) <u>Lillian</u> (Middle) <u>Loretta</u> (Last) <u>Grabenstein</u>			(Month) <u>Oct.</u> (Day) <u>11</u> (Year) <u>19 55</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>May 29-1910</u>		9. AGE last birthday: <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Vale Summit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>John Neat</u>			14. MOTHER'S MAIDEN NAME: <u>Loretta Higgins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	17. INFORMANT & ADDRESS: <u>Cumberland, Md.</u> <u>(sister) Alice Morgan (rural) Winchester</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Coronary occlusion</u> DUE TO					
Antecedent cause(s) (b) <u>Coronary sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct. 11-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul's Cem. Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Winters F. Frank, M.D.</u>		24. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Maryland</u>	

Outside of City Limits

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

10501

10501

BUREAU V. R.

OCT 12 1953

RECEIVED

09262

9247

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>				TOWN <u>Cumberland,</u>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
16 So. Mechanic St.,				16 So. Mechanic St.,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>MARGARET ELLA HARBAUGH</u>				<u>Oct. 7, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Dec. 16, 1882</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Owner & Proprietor Retail book store</u>			<u>New Baltimore, Penna.</u>		<u>U. S.</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frank L. Harbaugh</u>				<u>Martha Hickey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No,</u>		<u>214-32-5468</u>		<u>Cumberland, Md.</u>			
				<u>Miss Rose E. Harbaugh 16 So. Mechanic St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>420-1 Congestive heart failure</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO							
<u>arteriosclerotic heart disease</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
<u>generalized arteriosclerosis</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-3, 19 55</u> , to <u>10-7, 19 55</u> , that I last saw the deceased alive on <u>10-7-19 55</u> , and that death occurred at <u>11:40P</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>W. H. Hines</u>		<u>576 Avenue St. Cumberland Md</u>		<u>10-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/11/55</u>		<u>S. S. Peter & Pauls'</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>October 11, 1955</u>		<u>Walter R. Hantz, M.D.</u>		<u>Charles L. George</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

1 Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

00583

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

1913

State of Maryland

County of Baltimore

City of Baltimore

Age 45

Male

Dec 10 1913

Dec 10 1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

BUREAU V. H.

1913

RECEIVED

1913

1913

1913

1913

NOTIFICATION

1 With certificate limit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09263

9248

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> <u>02</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u> <u>308 Paca Street</u>				STREET ADDRESS (If rural give location) <u>308 Paca Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Katherine</u> (Last) <u>Hast</u>				(Month) <u>10</u> (Day) <u>25</u> (Year) <u>55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>August 13 1969</u>	
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frederick Hast</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Lochner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Julius Hast Cumberland Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>443 X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arterial Hypertension</u>				<u>3 years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u> to <u>Oct 25, 55</u> , that I last saw the deceased alive on <u>Oct 22, 1955</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. W. Truskakis</u> M.D.				DATE SIGNED <u>220 Baltimore</u> <u>Cumberland</u> <u>Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>10-28-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke Cemetery</u>	
24. REC'D BY REGISTRAR <u>Oct 26, 1955</u> <u>Winters R. Frantz, M.D.</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumberland Maryland</u>			

CERTIFICATE OF DEATH

RECEIVED

OCT 27 1955

BUREAU V. S.

ENCLOSURE

1. NAME (Last, first, middle) <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		11. SIGNATURE OF DEATH CERTIFICATE <i>J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>J. H. Smith</i>	
13. DATE OF DEATH <i>Oct 25 1955</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. PLACE OF DEATH <i>Home</i>	
16. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		17. NAME OF PHYSICIAN <i>J. H. Smith</i>		18. NAME OF NURSE <i>M. J. Brown</i>	
19. NAME OF FUNERAL HOME <i>John Doe & Co.</i>		20. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		21. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
22. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		23. NAME OF MINISTER <i>Rev. J. H. Smith</i>		24. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
25. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		26. NAME OF MINISTER <i>Rev. J. H. Smith</i>		27. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
28. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		29. NAME OF MINISTER <i>Rev. J. H. Smith</i>		30. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
31. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		32. NAME OF MINISTER <i>Rev. J. H. Smith</i>		33. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
34. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		35. NAME OF MINISTER <i>Rev. J. H. Smith</i>		36. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
37. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		38. NAME OF MINISTER <i>Rev. J. H. Smith</i>		39. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
40. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		41. NAME OF MINISTER <i>Rev. J. H. Smith</i>		42. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
43. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		44. NAME OF MINISTER <i>Rev. J. H. Smith</i>		45. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
46. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		47. NAME OF MINISTER <i>Rev. J. H. Smith</i>		48. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
49. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		50. NAME OF MINISTER <i>Rev. J. H. Smith</i>		51. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
52. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		53. NAME OF MINISTER <i>Rev. J. H. Smith</i>		54. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
55. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		56. NAME OF MINISTER <i>Rev. J. H. Smith</i>		57. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
58. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		59. NAME OF MINISTER <i>Rev. J. H. Smith</i>		60. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
61. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		62. NAME OF MINISTER <i>Rev. J. H. Smith</i>		63. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
64. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		65. NAME OF MINISTER <i>Rev. J. H. Smith</i>		66. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
67. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		68. NAME OF MINISTER <i>Rev. J. H. Smith</i>		69. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
70. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		71. NAME OF MINISTER <i>Rev. J. H. Smith</i>		72. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
73. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		74. NAME OF MINISTER <i>Rev. J. H. Smith</i>		75. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
76. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		77. NAME OF MINISTER <i>Rev. J. H. Smith</i>		78. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
79. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		80. NAME OF MINISTER <i>Rev. J. H. Smith</i>		81. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
82. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		83. NAME OF MINISTER <i>Rev. J. H. Smith</i>		84. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
85. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		86. NAME OF MINISTER <i>Rev. J. H. Smith</i>		87. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
88. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		89. NAME OF MINISTER <i>Rev. J. H. Smith</i>		90. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
91. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		92. NAME OF MINISTER <i>Rev. J. H. Smith</i>		93. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
94. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		95. NAME OF MINISTER <i>Rev. J. H. Smith</i>		96. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
97. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		98. NAME OF MINISTER <i>Rev. J. H. Smith</i>		99. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
100. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		101. NAME OF MINISTER <i>Rev. J. H. Smith</i>		102. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	

9249 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>8 days</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>613 Sedgwick St., City</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Wilbert Daniel Hospelhorn</u>				<u>10/ 17 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1/1/1898</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Traffic Manager</u>		<u>Railroad</u>		<u>Emmitsburg, Md.</u>		<u>USA</u>	
13. FATHER'S NAME <u>Bertram Hospelhorn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shoemaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>705-10-4594</u>		<u>Patient's Chart</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/9</u> , 19 <u>55</u> , to <u>10/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>55</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schindler</u>				ADDRESS (Street, city, town, state) <u>41 Green St. Cumberland, Md.</u>			
DATE <u>Oct. 20, 1955</u>				DATE SIGNED <u>10/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Kight</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3219 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Rev. Dec. 1954

1. USUAL RESIDENCE (NAME OF DECEASED)

2. PLACE OF DEATH

3. TIME OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. DATE OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RACE

13. BIRTH DATE

14. BIRTH PLACE

15. DATE OF BIRTH

16. SEX

17. AGE

18. OCCUPATION

19. MARITAL STATUS

20. EDUCATION

21. RACE

22. BIRTH DATE

23. BIRTH PLACE

24. DATE OF BIRTH

25. SEX

26. AGE

27. OCCUPATION

28. MARITAL STATUS

29. EDUCATION

30. RACE

31. BIRTH DATE

32. BIRTH PLACE

33. DATE OF BIRTH

34. SEX

35. AGE

36. OCCUPATION

37. MARITAL STATUS

38. EDUCATION

39. RACE

40. BIRTH DATE

41. BIRTH PLACE

42. DATE OF BIRTH

43. SEX

44. AGE

45. OCCUPATION

46. MARITAL STATUS

47. EDUCATION

48. RACE

49. BIRTH DATE

50. BIRTH PLACE

51. DATE OF BIRTH

52. SEX

53. AGE

54. OCCUPATION

55. MARITAL STATUS

56. EDUCATION

57. RACE

58. BIRTH DATE

59. BIRTH PLACE

60. DATE OF BIRTH

61. SEX

62. AGE

63. OCCUPATION

64. MARITAL STATUS

65. EDUCATION

66. RACE

67. BIRTH DATE

68. BIRTH PLACE

69. DATE OF BIRTH

70. SEX

71. AGE

72. OCCUPATION

73. MARITAL STATUS

74. EDUCATION

75. RACE

76. BIRTH DATE

77. BIRTH PLACE

78. DATE OF BIRTH

79. SEX

80. AGE

81. OCCUPATION

82. MARITAL STATUS

83. EDUCATION

84. RACE

85. BIRTH DATE

86. BIRTH PLACE

87. DATE OF BIRTH

88. SEX

89. AGE

90. OCCUPATION

91. MARITAL STATUS

92. EDUCATION

93. RACE

94. BIRTH DATE

95. BIRTH PLACE

96. DATE OF BIRTH

97. SEX

98. AGE

99. OCCUPATION

100. MARITAL STATUS

101. EDUCATION

102. RACE

103. BIRTH DATE

104. BIRTH PLACE

105. DATE OF BIRTH

106. SEX

107. AGE

108. OCCUPATION

109. MARITAL STATUS

110. EDUCATION

111. RACE

112. BIRTH DATE

113. BIRTH PLACE

114. DATE OF BIRTH

115. SEX

116. AGE

117. OCCUPATION

118. MARITAL STATUS

119. EDUCATION

120. RACE

121. BIRTH DATE

122. BIRTH PLACE

123. DATE OF BIRTH

124. SEX

125. AGE

126. OCCUPATION

127. MARITAL STATUS

128. EDUCATION

129. RACE

130. BIRTH DATE

131. BIRTH PLACE

132. DATE OF BIRTH

133. SEX

134. AGE

135. OCCUPATION

136. MARITAL STATUS

137. EDUCATION

138. RACE

139. BIRTH DATE

140. BIRTH PLACE

141. DATE OF BIRTH

142. SEX

143. AGE

144. OCCUPATION

145. MARITAL STATUS

146. EDUCATION

147. RACE

148. BIRTH DATE

149. BIRTH PLACE

150. DATE OF BIRTH

151. SEX

152. AGE

153. OCCUPATION

154. MARITAL STATUS

155. EDUCATION

156. RACE

157. BIRTH DATE

158. BIRTH PLACE

BUREAU V. 3

OCT 19 1955

RECEIVED

100-100000-100

RECEIVED
OCT 19 1955
BUREAU V. 3

9250

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2 days</u>		TOWN <u>Near Cumberland, rural</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #6, Narrows Park</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>GEORGE L. HUMPHREYS</u>				<u>OCTOBER 12, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 2, 1873</u>	<u>82 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Retired Manager - American Oil Company</u>				<u>Fairchance, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward W. Humphreys</u>				14. MOTHER'S MAIDEN NAME <u>Jane Jordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>214-05-4403</u>		<u>Memorial Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral vascular accident</u>				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/25</u> , 19 <u>55</u> , to <u>10/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/12</u> , 19 <u>55</u> , and that death occurred at <u>10/12</u> , 19 <u>55</u> , from the causes and on the date stated above.							
SIGNATURE <u>George M. Brown</u>				ADDRESS (Street, city, town, state) <u>Cumberland Md</u>		DATE SIGNED <u>10/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 14, 1955</u>		<u>Fairchance Cemetery</u>		<u>Fairchance, Pennsylvania.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 14, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>William H. Kight, Cumberland, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

10525

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1950

DATE OF DEATH

1. Usual residence of decedent at time of death

2. Date of death

3. Place of death

4. Cause of death

5. Manner of death

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Date of death

11. Place of death

12. Cause of death

13. Manner of death

14. Date of death

15. Place of death

16. Cause of death

17. Manner of death

18. Date of death

19. Place of death

20. Cause of death

21. Manner of death

22. Date of death

23. Place of death

24. Cause of death

25. Manner of death

26. Date of death

27. Place of death

28. Cause of death

29. Manner of death

30. Date of death

31. Place of death

32. Cause of death

33. Manner of death

34. Date of death

35. Place of death

36. Cause of death

37. Manner of death

38. Date of death

39. Place of death

40. Cause of death

41. Manner of death

42. Date of death

43. Place of death

44. Cause of death

45. Manner of death

46. Date of death

47. Place of death

48. Cause of death

49. Manner of death

50. Date of death

51. Place of death

52. Cause of death

53. Manner of death

54. Date of death

55. Place of death

56. Cause of death

57. Manner of death

58. Date of death

59. Place of death

60. Cause of death

61. Manner of death

62. Date of death

63. Place of death

64. Cause of death

65. Manner of death

66. Date of death

67. Place of death

68. Cause of death

69. Manner of death

BUREAU V. S.

OCT 17 1950

RECEIVED

NOTIFICATION

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

9293

CERTIFICATE OF DEATH

09266

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Rural, Cumberland</u>		TOWN <u>Rural, Cumberland</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00</u> <u>R.F.D. 6, Cumberland</u>		<u>R.F.D. 6, Cumberland, Md.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>GEORGE</u> (Middle) <u>EISEL</u> (Last) <u>KEMP</u>		(Month) <u>Oct.</u> (Day) <u>3</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb. 24, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Ret. County Emp.</u>		<u>County Roads</u>	<u>Frostburg, Maryland</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>TRUMAN KEMP</u>		<u>ELIZABETH BAUM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<u>NO</u>		<u>214-16-2373</u>	<u>Mrs. Geo. Kemp, Rt. 6, Cumberland</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Dilatation of Heart</u>			<u>12 hours</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Heart Disease</u>			<u>several years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Nephritis</u>			<u>several years</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>8</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>Oct 3, 1955</u> , that I last saw the deceased alive on <u>Oct 3, 1955</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>F. Alan G. Murray</u> M.D.		ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>Ind</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 6, 1955</u>	<u>Frostburg Memorial Park</u>	<u>Frostburg, Maryland</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
<u>Oct. 6, 1955</u>	<u>Walter R. Hantz, M.D.</u>	<u>John J. Hafer, Cumberland, Maryland</u>	

CERTIFICATE OF DEATH

REG. GEN. 12

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF POWER

39. SIGNATURE OF WEALTH

40. SIGNATURE OF POVERTY

41. SIGNATURE OF KNOWLEDGE

42. SIGNATURE OF IGNORANCE

43. SIGNATURE OF TRUTH

44. SIGNATURE OF LIES

45. SIGNATURE OF GOOD

46. SIGNATURE OF EVIL

47. SIGNATURE OF LOVE

48. SIGNATURE OF HATE

49. SIGNATURE OF HOPE

50. SIGNATURE OF DESPAIR

51. SIGNATURE OF FAITH

52. SIGNATURE OF DOUBT

53. SIGNATURE OF BELIEF

54. SIGNATURE OF UNBELIEF

55. SIGNATURE OF COURAGE

56. SIGNATURE OF COWARDICE

57. SIGNATURE OF BRAVERY

58. SIGNATURE OF TIMIDITY

59. SIGNATURE OF MODesty

60. SIGNATURE OF VANITY

61. SIGNATURE OF HUMILITY

62. SIGNATURE OF PRIDE

63. SIGNATURE OF MEekness

64. SIGNATURE OF RAGE

65. SIGNATURE OF GENTLENESS

66. SIGNATURE OF RIGHTEOUSNESS

67. SIGNATURE OF UNRIGHTEOUSNESS

68. SIGNATURE OF CLEANLINESS

69. SIGNATURE OF DIRTY

70. SIGNATURE OF ORDER

71. SIGNATURE OF DISORDER

72. SIGNATURE OF CLEANLINESS

73. SIGNATURE OF DIRTY

74. SIGNATURE OF ORDER

75. SIGNATURE OF DISORDER

76. SIGNATURE OF CLEANLINESS

77. SIGNATURE OF DIRTY

78. SIGNATURE OF ORDER

79. SIGNATURE OF DISORDER

80. SIGNATURE OF CLEANLINESS

81. SIGNATURE OF DIRTY

82. SIGNATURE OF ORDER

83. SIGNATURE OF DISORDER

84. SIGNATURE OF CLEANLINESS

85. SIGNATURE OF DIRTY

86. SIGNATURE OF ORDER

87. SIGNATURE OF DISORDER

88. SIGNATURE OF CLEANLINESS

89. SIGNATURE OF DIRTY

90. SIGNATURE OF ORDER

91. SIGNATURE OF DISORDER

92. SIGNATURE OF CLEANLINESS

93. SIGNATURE OF DIRTY

94. SIGNATURE OF ORDER

95. SIGNATURE OF DISORDER

96. SIGNATURE OF CLEANLINESS

97. SIGNATURE OF DIRTY

98. SIGNATURE OF ORDER

99. SIGNATURE OF DISORDER

100. SIGNATURE OF CLEANLINESS

101. SIGNATURE OF DIRTY

102. SIGNATURE OF ORDER

103. SIGNATURE OF DISORDER

104. SIGNATURE OF CLEANLINESS

105. SIGNATURE OF DIRTY

106. SIGNATURE OF ORDER

107. SIGNATURE OF DISORDER

108. SIGNATURE OF CLEANLINESS

109. SIGNATURE OF DIRTY

110. SIGNATURE OF ORDER

111. SIGNATURE OF DISORDER

112. SIGNATURE OF CLEANLINESS

113. SIGNATURE OF DIRTY

114. SIGNATURE OF ORDER

115. SIGNATURE OF DISORDER

116. SIGNATURE OF CLEANLINESS

117. SIGNATURE OF DIRTY

118. SIGNATURE OF ORDER

119. SIGNATURE OF DISORDER

120. SIGNATURE OF CLEANLINESS

121. SIGNATURE OF DIRTY

122. SIGNATURE OF ORDER

123. SIGNATURE OF DISORDER

124. SIGNATURE OF CLEANLINESS

125. SIGNATURE OF DIRTY

126. SIGNATURE OF ORDER

127. SIGNATURE OF DISORDER

128. SIGNATURE OF CLEANLINESS

129. SIGNATURE OF DIRTY

130. SIGNATURE OF ORDER

131. SIGNATURE OF DISORDER

132. SIGNATURE OF CLEANLINESS

133. SIGNATURE OF DIRTY

134. SIGNATURE OF ORDER

135. SIGNATURE OF DISORDER

136. SIGNATURE OF CLEANLINESS

137. SIGNATURE OF DIRTY

138. SIGNATURE OF ORDER

139. SIGNATURE OF DISORDER

140. SIGNATURE OF CLEANLINESS

141. SIGNATURE OF DIRTY

142. SIGNATURE OF ORDER

143. SIGNATURE OF DISORDER

144. SIGNATURE OF CLEANLINESS

145. SIGNATURE OF DIRTY

146. SIGNATURE OF ORDER

147. SIGNATURE OF DISORDER

148. SIGNATURE OF CLEANLINESS

149. SIGNATURE OF DIRTY

150. SIGNATURE OF ORDER

151. SIGNATURE OF DISORDER

152. SIGNATURE OF CLEANLINESS

153. SIGNATURE OF DIRTY

154. SIGNATURE OF ORDER

155. SIGNATURE OF DISORDER

156. SIGNATURE OF CLEANLINESS

157. SIGNATURE OF DIRTY

158. SIGNATURE OF ORDER

159. SIGNATURE OF DISORDER

160. SIGNATURE OF CLEANLINESS

161. SIGNATURE OF DIRTY

162. SIGNATURE OF ORDER

163. SIGNATURE OF DISORDER

164. SIGNATURE OF CLEANLINESS

165. SIGNATURE OF DIRTY

166. SIGNATURE OF ORDER

167. SIGNATURE OF DISORDER

168. SIGNATURE OF CLEANLINESS

169. SIGNATURE OF DIRTY

170. SIGNATURE OF ORDER

171. SIGNATURE OF DISORDER

172. SIGNATURE OF CLEANLINESS

173. SIGNATURE OF DIRTY

174. SIGNATURE OF ORDER

175. SIGNATURE OF DISORDER

176. SIGNATURE OF CLEANLINESS

177. SIGNATURE OF DIRTY

178. SIGNATURE OF ORDER

179. SIGNATURE OF DISORDER

180. SIGNATURE OF CLEANLINESS

181. SIGNATURE OF DIRTY

182. SIGNATURE OF ORDER

183. SIGNATURE OF DISORDER

184. SIGNATURE OF CLEANLINESS

185. SIGNATURE OF DIRTY

186. SIGNATURE OF ORDER

187. SIGNATURE OF DISORDER

188. SIGNATURE OF CLEANLINESS

189. SIGNATURE OF DIRTY

190. SIGNATURE OF ORDER

191. SIGNATURE OF DISORDER

192. SIGNATURE OF CLEANLINESS

193. SIGNATURE OF DIRTY

194. SIGNATURE OF ORDER

195. SIGNATURE OF DISORDER

196. SIGNATURE OF CLEANLINESS

197. SIGNATURE OF DIRTY

198. SIGNATURE OF ORDER

199. SIGNATURE OF DISORDER

200. SIGNATURE OF CLEANLINESS

201. SIGNATURE OF DIRTY

202. SIGNATURE OF ORDER

203. SIGNATURE OF DISORDER

204. SIGNATURE OF CLEANLINESS

205. SIGNATURE OF DIRTY

206. SIGNATURE OF ORDER

207. SIGNATURE OF DISORDER

208. SIGNATURE OF CLEANLINESS

209. SIGNATURE OF DIRTY

210. SIGNATURE OF ORDER

211. SIGNATURE OF DISORDER

212. SIGNATURE OF CLEANLINESS

213. SIGNATURE OF DIRTY

214. SIGNATURE OF ORDER

215. SIGNATURE OF DISORDER

216. SIGNATURE OF CLEANLINESS

217. SIGNATURE OF DIRTY

218. SIGNATURE OF ORDER

219. SIGNATURE OF DISORDER

220. SIGNATURE OF CLEANLINESS

221. SIGNATURE OF DIRTY

222. SIGNATURE OF ORDER

223. SIGNATURE OF DISORDER

224. SIGNATURE OF CLEANLINESS

225. SIGNATURE OF DIRTY

226. SIGNATURE OF ORDER

227. SIGNATURE OF DISORDER

228. SIGNATURE OF CLEANLINESS

229. SIGNATURE OF DIRTY

230. SIGNATURE OF ORDER

231. SIGNATURE OF DISORDER

232. SIGNATURE OF CLEANLINESS

233. SIGNATURE OF DIRTY

234. SIGNATURE OF ORDER

235. SIGNATURE OF DISORDER

236. SIGNATURE OF CLEANLINESS

237. SIGNATURE OF DIRTY

238. SIGNATURE OF ORDER

239. SIGNATURE OF DISORDER

240. SIGNATURE OF CLEANLINESS

241. SIGNATURE OF DIRTY

242. SIGNATURE OF ORDER

243. SIGNATURE OF DISORDER

244. SIGNATURE OF CLEANLINESS

245. SIGNATURE OF DIRTY

246. SIGNATURE OF ORDER

247. SIGNATURE OF DISORDER

248. SIGNATURE OF CLEANLINESS

249. SIGNATURE OF DIRTY

250. SIGNATURE OF ORDER

251. SIGNATURE OF DISORDER

252. SIGNATURE OF CLEANLINESS

253. SIGNATURE OF DIRTY

254. SIGNATURE OF ORDER

255. SIGNATURE OF DISORDER

256. SIGNATURE OF CLEANLINESS

257. SIGNATURE OF DIRTY

258. SIGNATURE OF ORDER

259. SIGNATURE OF DISORDER

260. SIGNATURE OF CLEANLINESS

261. SIGNATURE OF DIRTY

262. SIGNATURE OF ORDER

263. SIGNATURE OF DISORDER

264. SIGNATURE OF CLEANLINESS

265. SIGNATURE OF DIRTY

266. SIGNATURE OF ORDER

267. SIGNATURE OF DISORDER

268. SIGNATURE OF CLEANLINESS

269. SIGNATURE OF DIRTY

270. SIGNATURE OF ORDER

271. SIGNATURE OF DISORDER

272. SIGNATURE OF CLEANLINESS

273. SIGNATURE OF DIRTY

274. SIGNATURE OF ORDER

275. SIGNATURE OF DISORDER

276. SIGNATURE OF CLEANLINESS

277. SIGNATURE OF DIRTY

278. SIGNATURE OF ORDER

279. SIGNATURE OF DISORDER

280. SIGNATURE OF CLEANLINESS

281. SIGNATURE OF DIRTY

282. SIGNATURE OF ORDER

283.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09267

9280

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>2 days</u>		TOWN <u>Eckhart Mines</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles E. Lewis, Sr.</u>				<u>10 4 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>2-14-1901</u>	<u>54</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Custodian</u>		<u>Celanese Corp.</u>		<u>Eckhart</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel T. Lewis</u>				<u>Annie Barnard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>214-07-0042</u>		<u>Eckhart, Md.</u> <u>Chas. E. Lewis, Jr. (Son)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>561,4</u> IMMEDIATE CAUSE (A) <u>BOWEL OBSTRUCTION (AND SURGICAL SHOCK)</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GANGRENOUS SMALL INTESTINE</u>						<u>32 HRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>INTESTINAL HEMORRHAGE WITH HERNIATION</u>						<u>2 HRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>OF INTESTINAL MUCOSA</u>						<u>33 HRS.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>10/4/55</u>		<u>GANGRENOUS AND "KNOTTED" INTESTINES PERITONITIS</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/3</u>, 19<u>55</u>, to <u>10/4</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/4</u>, 19<u>55</u>, and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Marjorie Rothstein M.D.</u>				<u>48 Broadway - Frostburg, Md.</u>		<u>10/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-7-55</u>		<u>St. Michael's Cemetery</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>10-7-55</u>		<u>Mrs. Nancy N. Rose</u>		<u>P.H. Mattingly</u>			
DATE				ADDRESS			
				<u>23 E. Main St., Frostburg, Md.</u>			

1992

BUREAU V. S.

5551 01-100

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

9251

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>502 Fayette St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary T. Lippold</u>				<u>10/30 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>6/3/1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Cumberland, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Geo. Doerner</u>				14. MOTHER'S MAIDEN NAME <u>Anna Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Regina Lippold 502 Fayette St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>450.0</u>				<u>Generalized arteriosclerosis</u>			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 45</u> , to <u>Oct 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schindler</u>		M.D. <u>H. I. Greenleaf</u>		ADDRESS (Street, City, Town, state) <u>Cumberland, Md</u>		DATE SIGNED <u>10/31/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>St's Peter & Paul Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Nov. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Prantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	

11-20-55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form 1-55-1

1. Name of deceased (Print or type)

2. Date of death (Month, day, year)

3. Place of death (City, State, and Country)

4. Cause of death (List all causes, beginning with the immediate cause)

5. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

6. Signature of physician (Print name and sign)

7. Signature of medical examiner (Print name and sign)

8. Signature of coroner (Print name and sign)

9. Signature of registrar (Print name and sign)

10. Signature of funeral director (Print name and sign)

11. Signature of informant (Print name and sign)

12. Date of filing (Month, day, year)

13. File number (Print or type)

14. Remarks (Print or type)

15. Remarks (Print or type)

16. Remarks (Print or type)

17. Remarks (Print or type)

18. Remarks (Print or type)

19. Remarks (Print or type)

20. Remarks (Print or type)

BUREAU V. 2

NOV 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>20 Yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u>	<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Sacred Heart Hospital.</u>			STREET ADDRESS (If rural, give location) <u>489 Goethe St.</u>		
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Franklin Columbus Litten</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 30 19 55</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 25-1889</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer - Cumberland Water Dept.</u>			9. AGE last birthday: <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10b. KIND OF BUSINESS OR INDUSTRY: <u>Cumberland Water Dept.</u>			11. BIRTHPLACE (State or foreign country): <u>Cherry Run, W. Va.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>George Litten</u>		
14. MOTHER'S MAIDEN NAME: <u>Frances (Hickerson)</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		
16. SOCIAL SECURITY No.: <u>220-10-2415</u>			17. INFORMANT & ADDRESS: <u>(daughter) Mary Johnson, Cumberland, Md.</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO				sudden.....	
Antecedent cause(s) (b)..... <u>Coronary sclerosis</u> DUE TO				?	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct 30-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Nov. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Mary's Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Cumberland, Maryland</u>		24. FUNERAL DIRECTOR: <u>Charles L. George</u>		ADDRESS: <u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 31, 1955</u>		REGISTRAR'S SIGNATURE: <u>Walter R. Frantz, M.D.</u>		25. ADDRESS: <u>George</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00821

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

3

3

BUREAU V. B.
NOV 1 1955

RECEIVED

9294

09270

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN Rural LaVale		CITY (If outside corporate limits write RURAL and give nearest town)	TOWN Frostburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	near Cumberland Highway Route #40		STREET ADDRESS	(If rural, give location) Route #1 Box 21	
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Grace	Evelyn	Lloyd	Oct.	19	55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		
female	white	single	Aug. 21, 1920		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.		
Clerk, Div. Supt. Office B&O.R.Ry.			35 yrs. Months Days Hours Min.		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Frostburg, Md.			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Daniel Lloyd			Vivian Dando		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
no			215-03-4305		
17. INFORMANT & ADDRESS:			(mother) Vivian D. Lloyd, Frostburg, Md.		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			sudden		
Immediate cause (a) 5th. degree burns of body. DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. (City or town) (County) (State)	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. (City or town) (County) (State)	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
Oct. 19/55 A. M.		work		Run-a-way Tractor trailer ran into automobile.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
H.V. Deming M.D. H.V. Danning M.D. M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED Oct. 19-1955					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		Oct. 21-1955		Memorial Park Cemetery Frostburg Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Oct. 21, 1955		Wm. R. Frank, M.D.		J. R. Durst Funeral Home, Frostburg, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 24 1955

RECEIVED

9295

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>5 Yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>820 National Highway</u>				STREET ADDRESS (If rural give location) <u>820 National Highway</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James J McAtee</u>				<u>October 20 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/5/1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Officer</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew McAtee</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Barr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>87 345 195</u>		17. INFORMANT & ADDRESS <u>C.A. Smith Cumberland, Md.</u>			
(If Yes, give war or dates of service) <u>War I & 2</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Auto</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Thrombosis</u>				<u>4 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Chronic Myocarditis</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Oct 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>55</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Clayton E. Jurek</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein, Inc. Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

OFF. DATE

1. NAME OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. COLOR

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SERVICE

15. PLACE OF DEATH

16. TIME OF DEATH

17. CAUSE OF DEATH

18. DATE OF DEATH

19. TIME OF DEATH

20. CAUSE OF DEATH

21. DATE OF DEATH

22. TIME OF DEATH

23. CAUSE OF DEATH

24. DATE OF DEATH

25. TIME OF DEATH

26. CAUSE OF DEATH

27. DATE OF DEATH

28. TIME OF DEATH

29. CAUSE OF DEATH

30. DATE OF DEATH

31. TIME OF DEATH

32. CAUSE OF DEATH

33. DATE OF DEATH

34. TIME OF DEATH

35. CAUSE OF DEATH

36. DATE OF DEATH

37. TIME OF DEATH

38. CAUSE OF DEATH

39. DATE OF DEATH

40. TIME OF DEATH

41. CAUSE OF DEATH

42. DATE OF DEATH

43. TIME OF DEATH

44. CAUSE OF DEATH

45. DATE OF DEATH

46. TIME OF DEATH

47. CAUSE OF DEATH

48. DATE OF DEATH

49. TIME OF DEATH

50. CAUSE OF DEATH

51. DATE OF DEATH

52. TIME OF DEATH

53. CAUSE OF DEATH

54. DATE OF DEATH

55. TIME OF DEATH

56. CAUSE OF DEATH

57. DATE OF DEATH

58. TIME OF DEATH

59. CAUSE OF DEATH

60. DATE OF DEATH

61. TIME OF DEATH

62. CAUSE OF DEATH

63. DATE OF DEATH

64. TIME OF DEATH

65. CAUSE OF DEATH

66. DATE OF DEATH

67. TIME OF DEATH

68. CAUSE OF DEATH

69. DATE OF DEATH

70. TIME OF DEATH

71. CAUSE OF DEATH

72. DATE OF DEATH

73. TIME OF DEATH

74. CAUSE OF DEATH

75. DATE OF DEATH

76. TIME OF DEATH

77. CAUSE OF DEATH

78. DATE OF DEATH

79. TIME OF DEATH

80. CAUSE OF DEATH

81. DATE OF DEATH

82. TIME OF DEATH

83. CAUSE OF DEATH

84. DATE OF DEATH

85. TIME OF DEATH

86. CAUSE OF DEATH

87. DATE OF DEATH

88. TIME OF DEATH

89. CAUSE OF DEATH

90. DATE OF DEATH

91. TIME OF DEATH

92. CAUSE OF DEATH

93. DATE OF DEATH

94. TIME OF DEATH

95. CAUSE OF DEATH

96. DATE OF DEATH

97. TIME OF DEATH

98. CAUSE OF DEATH

99. DATE OF DEATH

100. TIME OF DEATH

101. CAUSE OF DEATH

102. DATE OF DEATH

103. TIME OF DEATH

104. CAUSE OF DEATH

105. DATE OF DEATH

106. TIME OF DEATH

107. CAUSE OF DEATH

108. DATE OF DEATH

109. TIME OF DEATH

110. CAUSE OF DEATH

111. DATE OF DEATH

112. TIME OF DEATH

113. CAUSE OF DEATH

114. DATE OF DEATH

115. TIME OF DEATH

116. CAUSE OF DEATH

117. DATE OF DEATH

118. TIME OF DEATH

119. CAUSE OF DEATH

120. DATE OF DEATH

121. TIME OF DEATH

122. CAUSE OF DEATH

123. DATE OF DEATH

124. TIME OF DEATH

125. CAUSE OF DEATH

126. DATE OF DEATH

127. TIME OF DEATH

128. CAUSE OF DEATH

129. DATE OF DEATH

130. TIME OF DEATH

131. CAUSE OF DEATH

132. DATE OF DEATH

133. TIME OF DEATH

134. CAUSE OF DEATH

135. DATE OF DEATH

136. TIME OF DEATH

137. CAUSE OF DEATH

138. DATE OF DEATH

139. TIME OF DEATH

140. CAUSE OF DEATH

141. DATE OF DEATH

142. TIME OF DEATH

143. CAUSE OF DEATH

144. DATE OF DEATH

145. TIME OF DEATH

146. CAUSE OF DEATH

147. DATE OF DEATH

148. TIME OF DEATH

149. CAUSE OF DEATH

150. DATE OF DEATH

151. TIME OF DEATH

152. CAUSE OF DEATH

153. DATE OF DEATH

154. TIME OF DEATH

155. CAUSE OF DEATH

156. DATE OF DEATH

157. TIME OF DEATH

158. CAUSE OF DEATH

159. DATE OF DEATH

160. TIME OF DEATH

161. CAUSE OF DEATH

162. DATE OF DEATH

163. TIME OF DEATH

164. CAUSE OF DEATH

165. DATE OF DEATH

166. TIME OF DEATH

167. CAUSE OF DEATH

BUREAU V. S.

OCT 23 1955

RECEIVED

RECEIVED

9253

CERTIFICATE OF DEATH

DR. JACOBSON Items 8,9, Film 188 11-4-55 et

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		32 DAYS		02 TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				615 GREENE STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
ETHEL MC CARTY				OCTOBER 29 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	1893 AUGUST 6, 1894	63 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE and Secretary for Lawyer				WASHINGTON, D.C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES SHUGRUE SHUGRUE				MARTHA WESTBROOK WESTBROOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170x IMMEDIATE CAUSE (A) Metastatic Carcinomatosis							
ANTECEDENT CAUSE(S) DUE TO Carcinoma Breast							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
1953		Carcinoma of Breast				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 17 Oct 1955, to 29 Oct 1955, that I last saw the deceased alive on 29 Oct 1955, and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Heville G. Weissman, M.D.				Cumberland Maryland		Oct 31, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10-31-55		Hillcrest Cemetery		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		Signature R. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

9254 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY GARRETT	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 12 TOWN CUMBERLAND		LENGTH OF STAY (In this place) 3 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FROSTBURG, rural		11X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) RT. #2			
3. NAME OF DECEASED (First) (Middle) (Last) EDNA F. MICHAEL				4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 7, 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 10, 1911		9. AGE last birthday 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Local Registrar & Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BERTRAND BAER				14. MOTHER'S MAIDEN NAME DOLL FINZEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL WARWICK & MEMORIAL AVE		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 340.1 Meningitis, acute, Pneumococcus						INTERVAL BETWEEN ONSET AND DEATH 2 Oct. 55	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						Oct 7 Oct. 55	
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 2			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 4 Oct. 19 55, to 7 Oct. 19 55, that I last saw the deceased alive on 7 Oct. 19 55, and that death occurred at 7:00 PM, from the causes and on the date stated above.							
SIGNATURE W. Alfred Van Ormer				ADDRESS (Street, city, town, state) M.D. Cumberland, Md		DATE SIGNED 8 Oct 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10-12-55	NAME OF CEMETERY OR CREMATORY Finzel Cemetery		LOCATION (City, town, or county) Finzel		(State) Md.	
24. REC'D BY REGISTRAR October 11, 1955	REGISTRAR'S SIGNATURE Winter R. Frankz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durek		ADDRESS Frostburg, Md.		

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DEATH CERTIFICATE

IN DEPOSIT - ST. JOHN'S HOSPITAL, BALTIMORE, MD. 1955

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED EDWARD J. BROWN</p>		<p>2. SEX MALE</p>		<p>3. AGE 45</p>	
<p>4. PLACE OF BIRTH BALTIMORE, MD.</p>		<p>5. OCCUPATION CLERK</p>		<p>6. DATE OF DEATH 10-10-55</p>	
<p>7. PLACE OF DEATH ST. JOHN'S HOSPITAL</p>		<p>8. CAUSE OF DEATH HEART DISEASE</p>		<p>9. MANNER OF DEATH NATURAL</p>	
<p>10. SIGNATURE OF PHYSICIAN DR. J. H. BROWN</p>		<p>11. SIGNATURE OF WITNESS DR. J. H. BROWN</p>		<p>12. SIGNATURE OF DECEASED EDWARD J. BROWN</p>	
<p>13. SIGNATURE OF DECEASED EDWARD J. BROWN</p>		<p>14. SIGNATURE OF DECEASED EDWARD J. BROWN</p>		<p>15. SIGNATURE OF DECEASED EDWARD J. BROWN</p>	

RECEIVED
 OCT 11 1955
 BUREAU V. 8

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09274

Item 21f Film G188 10-24-55 amc

9281

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>22</u> TOWN <u>Frostburg</u>		<u>2 weeks</u>		TOWN <u>Midland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miner's Hospital</u>				STREET ADDRESS (If rural give location) <u>1 Dan's Rock Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Hester</u> (Middle) <u>W.</u> (Last) <u>Morton</u>				(Month) <u>Oct.</u> (Day) <u>10th.</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 24th, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Jacob Winters</u>				14. MOTHER'S MAIDEN NAME <u>Louise Humbertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>None</u>		<u>Marshall Morton, Midland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>904.0</u> IMMEDIATE CAUSE (A) <u>STASIS PNEUMONIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fractured Hip</u>				<u>2 wks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>home Midland Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 23 5545</u> M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> <u>Fell to floor at home</u>					
22. I hereby certify that I attended the deceased from <u>Sept 23, 19 55</u> , to <u>Oct 10, 19 55</u> , that I last saw the deceased alive on <u>Oct 10, 19 55</u> , and that death occurred at <u>10/11/55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John P. Durst</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>10/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 13th, 55</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Nanny H. Rie</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>			

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9255 CERTIFICATE OF DEATH

09275

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Cumberland,</u>	<u>02</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08 121 Paca St.,</u>		STREET ADDRESS (If rural give location) <u>121 Paca St.,</u>	<u>1</u>
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN J. MUIR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 19, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 21, 1877</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>19 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miner</u>	
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Muir</u>		14. MOTHER'S MAIDEN NAME <u>Mary Todd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-6732</u>	
17. INFORMANT & ADDRESS <u>Angela Muir Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>141X</u> IMMEDIATE CAUSE (A) <u>Cerebrovascular of Tongue with Wet Stroke</u> ANTECEDENT CAUSE(S) DUE TO (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 54</u> <u>October 18, 19 55</u> , to <u>19 55</u> , that I last saw the deceased <u>alive on</u> <u>19 55</u> , and that death occurred at <u>8:50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. J. J. J.</u>		DATE SIGNED <u>11-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Winters R. Frank, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		26. ADDRESS <u>Cumberland, Md.</u>	

0255 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Dist. No.

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF NOTARY

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF JAILER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF OF POLICE

24. SIGNATURE OF DETECTIVE

25. SIGNATURE OF OFFICER

26. SIGNATURE OF CONSTABLE

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF CLERK

30. SIGNATURE OF NOTARY

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF DEPUTY SHERIFF

33. SIGNATURE OF JAILER

34. SIGNATURE OF WARDEN

35. SIGNATURE OF CHIEF OF POLICE

36. SIGNATURE OF DETECTIVE

37. SIGNATURE OF OFFICER

38. SIGNATURE OF CONSTABLE

39. SIGNATURE OF JURY

40. SIGNATURE OF JUDGE

41. SIGNATURE OF CLERK

42. SIGNATURE OF NOTARY

43. SIGNATURE OF SHERIFF

44. SIGNATURE OF DEPUTY SHERIFF

45. SIGNATURE OF JAILER

46. SIGNATURE OF WARDEN

47. SIGNATURE OF CHIEF OF POLICE

48. SIGNATURE OF DETECTIVE

49. SIGNATURE OF OFFICER

50. SIGNATURE OF CONSTABLE

SHORT NOTICE

NOTICE TO THE PUBLIC: This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 24th day of October, 1955.

BUREAU V. 8

OCT 24 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09276

9296

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Eckhart,</u>				TOWN <u>Eckhart</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Route 40</u>				STREET ADDRESS (If rural give location) <u>Old Route 40</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>PHOEBE ANN NELSON</u>				<u>Oct. 25, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 15, 1886</u>	<u>69</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Listonburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Cyrus Huffman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. William Filsinger Rt. 2, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
692.1 IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arthritis & rheumatism</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>abscess left groin, incised & drainage</u>						<u>2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>9-6-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>abscess left groin & drainage</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, etc.) OF INJURY <u>street, office bldg., etc.</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-1</u> , 19 <u>55</u> , to <u>10-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>55</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. C. Siehl,</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>10-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery</u>		LOCATION (City, town, or county) (State) <u>Addison, Penna.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. Wayne George</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Cumberland, Maryland</u>			
DATE <u>10-27-55</u>							

CERTIFICATE OF DEATH

ATLANTIC STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

File No. 100

1. UNDER MEDICAL SUPERVISION

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH OFFICIAL

16. SIGNATURE OF OTHER OFFICIAL

17. SIGNATURE OF OTHER OFFICIAL

18. SIGNATURE OF OTHER OFFICIAL

19. SIGNATURE OF OTHER OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

23. SIGNATURE OF OTHER OFFICIAL

24. SIGNATURE OF OTHER OFFICIAL

25. SIGNATURE OF OTHER OFFICIAL

26. SIGNATURE OF OTHER OFFICIAL

27. SIGNATURE OF OTHER OFFICIAL

28. SIGNATURE OF OTHER OFFICIAL

29. SIGNATURE OF OTHER OFFICIAL

30. SIGNATURE OF OTHER OFFICIAL

31. SIGNATURE OF OTHER OFFICIAL

32. SIGNATURE OF OTHER OFFICIAL

33. SIGNATURE OF OTHER OFFICIAL

34. SIGNATURE OF OTHER OFFICIAL

35. SIGNATURE OF OTHER OFFICIAL

36. SIGNATURE OF OTHER OFFICIAL

37. SIGNATURE OF OTHER OFFICIAL

38. SIGNATURE OF OTHER OFFICIAL

39. SIGNATURE OF OTHER OFFICIAL

40. SIGNATURE OF OTHER OFFICIAL

41. SIGNATURE OF OTHER OFFICIAL

42. SIGNATURE OF OTHER OFFICIAL

43. SIGNATURE OF OTHER OFFICIAL

44. SIGNATURE OF OTHER OFFICIAL

45. SIGNATURE OF OTHER OFFICIAL

46. SIGNATURE OF OTHER OFFICIAL

47. SIGNATURE OF OTHER OFFICIAL

48. SIGNATURE OF OTHER OFFICIAL

49. SIGNATURE OF OTHER OFFICIAL

50. SIGNATURE OF OTHER OFFICIAL

51. SIGNATURE OF OTHER OFFICIAL

52. SIGNATURE OF OTHER OFFICIAL

53. SIGNATURE OF OTHER OFFICIAL

54. SIGNATURE OF OTHER OFFICIAL

55. SIGNATURE OF OTHER OFFICIAL

56. SIGNATURE OF OTHER OFFICIAL

57. SIGNATURE OF OTHER OFFICIAL

58. SIGNATURE OF OTHER OFFICIAL

59. SIGNATURE OF OTHER OFFICIAL

60. SIGNATURE OF OTHER OFFICIAL

61. SIGNATURE OF OTHER OFFICIAL

62. SIGNATURE OF OTHER OFFICIAL

63. SIGNATURE OF OTHER OFFICIAL

64. SIGNATURE OF OTHER OFFICIAL

65. SIGNATURE OF OTHER OFFICIAL

66. SIGNATURE OF OTHER OFFICIAL

67. SIGNATURE OF OTHER OFFICIAL

68. SIGNATURE OF OTHER OFFICIAL

69. SIGNATURE OF OTHER OFFICIAL

70. SIGNATURE OF OTHER OFFICIAL

71. SIGNATURE OF OTHER OFFICIAL

72. SIGNATURE OF OTHER OFFICIAL

73. SIGNATURE OF OTHER OFFICIAL

74. SIGNATURE OF OTHER OFFICIAL

75. SIGNATURE OF OTHER OFFICIAL

76. SIGNATURE OF OTHER OFFICIAL

77. SIGNATURE OF OTHER OFFICIAL

78. SIGNATURE OF OTHER OFFICIAL

79. SIGNATURE OF OTHER OFFICIAL

80. SIGNATURE OF OTHER OFFICIAL

81. SIGNATURE OF OTHER OFFICIAL

82. SIGNATURE OF OTHER OFFICIAL

83. SIGNATURE OF OTHER OFFICIAL

84. SIGNATURE OF OTHER OFFICIAL

85. SIGNATURE OF OTHER OFFICIAL

86. SIGNATURE OF OTHER OFFICIAL

87. SIGNATURE OF OTHER OFFICIAL

88. SIGNATURE OF OTHER OFFICIAL

89. SIGNATURE OF OTHER OFFICIAL

90. SIGNATURE OF OTHER OFFICIAL

91. SIGNATURE OF OTHER OFFICIAL

92. SIGNATURE OF OTHER OFFICIAL

93. SIGNATURE OF OTHER OFFICIAL

94. SIGNATURE OF OTHER OFFICIAL

95. SIGNATURE OF OTHER OFFICIAL

96. SIGNATURE OF OTHER OFFICIAL

97. SIGNATURE OF OTHER OFFICIAL

98. SIGNATURE OF OTHER OFFICIAL

99. SIGNATURE OF OTHER OFFICIAL

100. SIGNATURE OF OTHER OFFICIAL

101. SIGNATURE OF OTHER OFFICIAL

102. SIGNATURE OF OTHER OFFICIAL

103. SIGNATURE OF OTHER OFFICIAL

104. SIGNATURE OF OTHER OFFICIAL

105. SIGNATURE OF OTHER OFFICIAL

106. SIGNATURE OF OTHER OFFICIAL

107. SIGNATURE OF OTHER OFFICIAL

108. SIGNATURE OF OTHER OFFICIAL

109. SIGNATURE OF OTHER OFFICIAL

110. SIGNATURE OF OTHER OFFICIAL

111. SIGNATURE OF OTHER OFFICIAL

112. SIGNATURE OF OTHER OFFICIAL

113. SIGNATURE OF OTHER OFFICIAL

114. SIGNATURE OF OTHER OFFICIAL

115. SIGNATURE OF OTHER OFFICIAL

116. SIGNATURE OF OTHER OFFICIAL

117. SIGNATURE OF OTHER OFFICIAL

118. SIGNATURE OF OTHER OFFICIAL

119. SIGNATURE OF OTHER OFFICIAL

120. SIGNATURE OF OTHER OFFICIAL

121. SIGNATURE OF OTHER OFFICIAL

122. SIGNATURE OF OTHER OFFICIAL

123. SIGNATURE OF OTHER OFFICIAL

124. SIGNATURE OF OTHER OFFICIAL

125. SIGNATURE OF OTHER OFFICIAL

126. SIGNATURE OF OTHER OFFICIAL

127. SIGNATURE OF OTHER OFFICIAL

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or injury. It is to be filled out as soon as possible after death, and it is to be signed by the physician or other qualified person who has attended the deceased during his or her illness or injury. It is to be filed with the local health department, and it is to be kept for a period of ten years.

RECEIVED

1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9297 CERTIFICATE OF DEATH

09277

Reg. Dist. No. 10

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Mt. Savage</u>		LENGTH OF STAY (in this place) <u>life</u>		OR TOWN <u>Mt. Savage</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS <u>Main Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ADELLE</u> <u>NOONAN</u>				<u>Oct.</u> <u>22</u> , <u>19</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>8-12-1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housework</u>		<u>own home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Patrick O'Connor</u>				<u>Jane Stephens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Mrs. Paul Garlitz, Mt. Savage, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.							
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>26 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Previous Cerebral Hemorrhage</u>						<u>about 1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>NONE</u>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 21</u> , 19 <u>55</u> , to <u>OCT 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>55</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)			DATE SIGNED		
<u>Marion P. ...</u>		<u>48 Broadway - Frostburg Md. 10/24/55</u>			<u>10/24/55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-25-1955</u>		<u>St. Patrick's Cemetery</u>		<u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/24/1955</u>		<u>Veronica M. Dermott</u>		<u>J. R. Durst</u>		<u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

DEATH CERTIFICATE OF DEATH ON RECORD

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

BUREAU V. S.

OCT 28 1955

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1. The death certificate is a legal document which is required by law to be filed with the local health department within a certain period of time after the death of a person. It is a document which is used to determine the cause of death and to provide information to the family and to the public health authorities. It is a document which is used to determine the cause of death and to provide information to the family and to the public health authorities. It is a document which is used to determine the cause of death and to provide information to the family and to the public health authorities.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09278

9282

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
22 TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				274 E. Main			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Veronica</u> (Middle) <u>A.</u> (Last) <u>O'Rourke</u>				(Month) <u>10</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Married	7 - 16 - 1897	58 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Lonaconing		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Patrick Stakem				Esther Cavanaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				274 E. Main, Frostburg			
				Patrick A. O'Rourke, (Husband)			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>						Sudden	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension - the Nephritic</u>						16 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Myocardial Infarction</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while et work <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 54</u> , 19 <u>54</u> , to <u>Oct 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 26</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Lane</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>Nov 1 1955</u>	
M.D. <u>Frostburg</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/2/55		St. Michael's Cemetery Frostburg		Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-3-55</u>		<u>Mrs. Nancy N. Roe</u>		<u>B.H. Montecant</u>		23 E. Main Frostburg, Md.	

00258

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

0000

1. PLACE OF BIRTH

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

13. SIGNATURE

14. SIGNATURE

15. SIGNATURE

16. SIGNATURE

17. SIGNATURE

18. SIGNATURE

19. SIGNATURE

20. SIGNATURE

21. SIGNATURE

22. SIGNATURE

23. SIGNATURE

24. SIGNATURE

25. SIGNATURE

26. SIGNATURE

27. SIGNATURE

28. SIGNATURE

29. SIGNATURE

30. SIGNATURE

31. SIGNATURE

32. SIGNATURE

33. SIGNATURE

34. SIGNATURE

35. SIGNATURE

36. SIGNATURE

37. SIGNATURE

38. SIGNATURE

39. SIGNATURE

40. SIGNATURE

41. SIGNATURE

42. SIGNATURE

43. SIGNATURE

BUREAU V. S.

NOV 27 1953

RECEIVED

INSTRUCTIONS

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09279

9256 **CERTIFICATE OF DEATH**

Reg. Dist. No. 9

1. PLACE OF DEATH						2. USUAL RESIDENCE (HOME) OF DECEASED							
COUNTY <u>Allegany</u>				MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>							
CITY (If outside corporate limits, write RURAL OR end give nearest town)				LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN							
TOWN <u>Cumberland, Md.</u>				<u>60yrs</u>		TOWN <u>Cumberland, Maryland</u>				<u>02</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>33 Virginia Ave.</u>						STREET ADDRESS (If rural give location) <u>33 Virginia Ave.</u>						<u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ida Maude Perdew</u>						4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 10, 1955</u>							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 3, 1886</u>		9. AGE last birthday yrs. <u>68</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Wm. F. Kirby</u>						14. MOTHER'S MAIDEN NAME <u>Annie E. Paul</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>A. G. Perdew 33 Virginia Ave.</u>							
18. MEDICAL CERTIFICATION													
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Sclerosis - occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>													
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Allergic Bronchitis</u>													
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>40</u> , to....., 19....., that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>55</u> , and that death occurred at <u>2 P</u> .M, from the causes and on the date stated above. SIGNATURE <u>R. Dixie Rodbone</u> M.D. ADDRESS (Street, city, town, state) DATE SIGNED													
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>10-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>				LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>			
24. REC'D BY REGISTRAR <u>October 11, 1955</u>				REGISTRAR'S SIGNATURE <u>Winter R. Grant, M.D.</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>					

1954

BUREAU V. B.

13 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9257 **CERTIFICATE OF DEATH**

09280

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (in this place) 85 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL		STREET ADDRESS ROUTE #6 Narrows Park					
3. NAME OF DECEASED (First) (Middle) (Last) RAYMOND Sylvester PERDEW				4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 4 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY 9, 1890		9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.		11. BIRTHPLACE (State or foreign country) MARYLAND Flintstone		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Asbury PERDEW				14. MOTHER'S MAIDEN NAME EMILY JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No,		16. SOCIAL SECURITY NO. 705-10-7297		17. INFORMANT & ADDRESS Mrs. Ouida Perdeu Rt. # 6 Cumberland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Antecedent Cause(s) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)						INTERVAL BETWEEN ONSET AND DEATH July 9 to Oct 4 1955-2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 9, 1955, to Oct 4, 1955, that I last saw the deceased alive on Oct 4, 1955, and that death occurred at 9:55 P.M. from the causes and on the date stated above.							
SIGNATURE F. Alan G. Murray M.D.				ADDRESS (Street, city, town, state) Cumberland Md		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/7/55		NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		LOCATION (City, town, or county) Near Artemus, Penna.	
24. REC'D BY REGISTRAR DATE Oct. 7, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.A.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09281

9283

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22</u> TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>2</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61</u> <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>98 Mt. Pleasant St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM</u> <u>MAURICE</u> <u>PLUNKETT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10</u> - <u>11</u> - <u>19</u> <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1</u> - <u>5</u> - <u>1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Celanese Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Eckhart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice Plunkett</u>				14. MOTHER'S MAIDEN NAME <u>Helen Preston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-1414</u>		17. INFORMANT & ADDRESS <u>Frostburg, Md.</u> <u>Wm. L. Plunkett, 98 Mt. Pleasant St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>416x Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Constrictive Heart Failure</u>						<u>5-6 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Rheumatic Heart & Cor Pulmonale</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/15</u> , 19 <u>55</u> , to <u>10 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>55</u> , and that death occurred at <u>10/11</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>Jahoe Plunkett</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md.</u>		DATE SIGNED <u>10/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>10-15-55</u>		REGISTRAR'S SIGNATURE <u>Mr. Harry N. D. 2</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benleh H. Montecant</u>		ADDRESS <u>26 E. Main, Frostburg, Md.</u>	

CERTIFICATE OF DEATH

Reg. Off. No.

2. Legal Residence, Town or Village

3. Date of Death

4. Time of Death

5. Name of Deceased

6. Sex

7. Age

8. Marital Status

9. Date of Birth

10. Cause of Death

11. Place of Death

12. Signature of Physician

13. Signature of Registrar

14. Date of Registration

BUREAU V. S.

OCT 20 1955

RECEIVED

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Cumberland LENGTH OF STAY (in this place) 11 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN Cumberland

STREET ADDRESS (If rural, give location)
719 Patterson Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) RebeccaS.Poling

4. DATE OF DEATH (Month) (Day) (Year)
Oct. 26 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.
female white widow March 23-1871 84 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
housewife

10b. KIND OF BUSINESS OR INDUSTRY:
Own Home

11. BIRTHPLACE (State or foreign country):
Barbour Co. W. Va.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

Jesse Poling

14. MOTHER'S MAIDEN NAME:

Barbara Loan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY No.:
none

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260x
Immediate cause

(a) Myocardial failure
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Cardio-vascular disease with hypertention
DUE TO
(c) also had Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH
gradual

?
several years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Intratracheal fracture, left femur 11 days

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY home

21c. (City or town) (County) (State)
Cumberland Allegany Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Oct. 15-1955 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?
Went to sit on bed missed bed, fell to floor, fractured

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

Oct. 27-1955

23. BURIAL, CREMATION, REMOVAL (Specify):
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Oct. 29, 1955McNeely CemeteryHendricks, W. Va.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct. 28, 1955Walter R. Hartz, M.D.William H. Kight, Cumberland, Md.Kight

MARGIN RESERVED FOR BINDING

BUREAU V. 8

NOV 1 1965

RECEIVED

1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09283

9259 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND TOWN CUMBERLAND HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE TOWN MT. SAVAGE STREET ADDRESS NEW ROW			
3. NAME OF DECEASED (Type or Print) (First) BRADLEY (Middle) T. (Last) RICE				4. DATE OF DEATH (Month) (Day) (Year) OCT. 19 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB. 26, 1902	9. AGE last birthday 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE RICE				14. MOTHER'S MAIDEN NAME SARAH REESER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 215-10-1213		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153X IMMEDIATE CAUSE (A) Miliary metastatic carcinoma. ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of sigmoid. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Intestinal obstruction. Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 8 wks. 8 mos. 2 wks.			
19a. DATE OF OPERATION 10-12-55		19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction. Generalized metastases		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 1955 , to Oct. 19, 1955 , that I last saw the deceased alive on Oct. 19, 1955 , and that death occurred 12:10 P.M. from the causes and on the date stated above. SIGNATURE S. B. Imme ADDRESS (Street, city, town, state) M.D. 1225 Centre St Cumberland Md DATE SIGNED 10-19-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 22, 1955		NAME OF CEMETERY OR CREMATORY St. George's Episcopal Cem.		LOCATION (City, town, or county) (State) Mt. Savage, Maryland	
24. REC'D BY REGISTRAR Oct. 31, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Maryland.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1919 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

1919

REGISTRATION NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. COLOR

9. OCCUPATION

10. MARITAL STATUS

11. PLACE OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. DATE OF REGISTRATION

15. MEDICAL CERTIFICATION

BUREAU V. S.

OCT 24 1955

RECEIVED

RECEIVED

RECEIVED

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9298

CERTIFICATE OF DEATH

09284

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MD.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Midland</u>		LENGTH OF STAY (in this place)		TOWN <u>Midland</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Railroad Street</u>				STREET ADDRESS <u>Railroad Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>RICKER</u> (Last)				(Month) <u>Oct.</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 10. 1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Employee of Dairy</u>		<u>Dairy</u>		<u>Lonaconing, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frank Ricker</u>				<u>Mary Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>213-09-6499</u>		<u>Mrs. William McKinley, Midland, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)			
IMMEDIATE CAUSE (A) <u>153X INANITION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ADENOCARCINOMA Colon</u>				<u>1-2 1/2 RS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>260X Diabetes Mellitus</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5</u>, 19<u>55</u>, to <u>10/13</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9/30</u>, 19<u>55</u>, and that death occurred at <u>1 P.</u>M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>John C. Dovers</u>		<u>Frostburg MD</u>		<u>10/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 15. 1955.</u>		<u>St. Michaels Cemetery.</u>		<u>Frostburg, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>10-14-55</u>		<u>Jeanette M Boal</u>		<u>George Eichhorn, Lonaconing, MD.</u>			

1
Without corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09285

9260

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE WYOMING MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		11 DAYS		TOWN KEYSER McCOOLE		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				Waxler Road			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
WALTER		B RILEY		10-28		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	SEPT. 22, 1899	56 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer			Construction	ZANESVILLE, OHIO		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY RILEY				IDA SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-10-6923		Mrs. Minnie Riley, R.F.D. #3, Keyser, VA.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						VA.	
434.3 IMMEDIATE CAUSE (A) Uremia						1 week	
ANTECEDENT CAUSE(S) DUE TO Renal Failure (Renal Shutdown)						3 day	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Cor Pulmonale Chron						4 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Emphysema + Fibrosis						4 year	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 57, to 28 Oct, 19 55, that I last saw the deceased alive on 28 Oct, 19 55, and that death occurred at 9:55 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
H. C. Weisman				M.D. 59 Greene St Cumberland Md		31 Oct 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 31, 1955		Queen's Point Cemetery		Keyser, West Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct. 31, 1955		Winters L. Frantz, M.D.		Rogers Funeral Home - Keyser, W. Va.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2107751231

RECEIVED
JAN 1 1935
BUREAU V. 8

3250 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED WILLIAM W. WILSON		2. SEX MALE		3. AGE 45	
4. RACE WHITE		5. BIRTH DATE JAN 15 1890		6. BIRTH PLACE BALTIMORE, MARYLAND	
7. OCCUPATION LABORER		8. MARITAL STATUS MARRIED		9. PLACE OF DEATH BALTIMORE, MARYLAND	
10. CAUSE OF DEATH HEART DISEASE		11. DATE OF DEATH JAN 1 1935		12. TIME OF DEATH 10:30 AM	
13. SIGNATURE OF PHYSICIAN J. H. WILSON		14. SIGNATURE OF WITNESSES J. H. WILSON		15. SIGNATURE OF REGISTRAR J. H. WILSON	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09286

9284

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
22 TOWN <u>Frostburg</u>		23 days		TOWN <u>Frostburg,</u>		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miner's Hospital</u>				186 W. Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Antonio</u> <u>Ruffo</u>				Oct. 1, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	June 15th, 1866	89 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Miner		Coal Mining		Italy		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		None		Carl Ruffo, Washington St., F'bg. Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
144X IMMEDIATE CAUSE (A) <u>CARLINOTHA BUCAL MUCOSA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						1 YR	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/30, 1955, to 10/1, 1955, that I last saw the deceased alive on 9/30, 1955, and that death occurred at 3 A.M. from the causes and on the date stated above.							
SIGNATURE <u>John P. Deenert</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u> DATE SIGNED <u>10/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 3, 1955		St. Michael's Cemetery		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-3-55</u>		<u>Mr. Nancy H. Rea</u>		<u>Joseph R. Durst</u>		<u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
JAMES W. HARRIS		Male		White		1880		New York		New York		Heart Disease		Natural		New York		October 6, 1955		10:00 AM		J. W. Harris		J. W. Harris	
Age		Married		Single		Occupation		Education		Religion		Previous Illnesses		Alcohol		Tobacco		Drugs		Other		Signature of Informant		Signature of Informant	
75		Yes		No		Coal Miner		High School		Catholic		None		None		None		None		None		J. W. Harris		J. W. Harris	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant	
October 6, 1955		10:00 AM		New York		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris		J. W. Harris	

BUREAU V. S.

OCT 6 1955

RECEIVED

Oct. 6, 1955 St. Michael's Cemetery, Brooklyn, N.Y.

Joseph R. Harris, Brooklyn, N.Y.

NOTIFICATION

Attention is directed to the fact that the death of the deceased has been reported to the Bureau of Vital Statistics, New York City, and that a copy of the death certificate has been forwarded to the Bureau of Vital Statistics, New York State, for filing. It is requested that you advise the Bureau of Vital Statistics, New York City, of any change in the information furnished on this certificate.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

I. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Cumberland LENGTH OF STAY (in this place) 10 min.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W.Va. COUNTY Hampshire
 CITY (If outside corporate limits write RURAL and give nearest town)
 TOWN Romney 85X-3
 STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

DECEASED: (Type or Print) Allen Edwin Russell

4. DATE OF DEATH

(Month)

(Day)

(Year)

Oct. 2 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

(wife) Leona E. Lloyd Russell, Romney, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

241X
Immediate cause (a) Coronary occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(b) Coronary sclerosis also had
 (c) Bronchial asthma

INTERVAL BETWEEN ONSET AND DEATH

4 hrs.

?

about

10 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D. H.V. Deming M.D. M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

Oct. 2-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct. 3, 1955

Walter R. Krantz, M.D.

Combs Funeral Home, Romney, W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 4 1955

RECEIVED

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9262 CERTIFICATE OF DEATH

09288

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		17 days		TOWN <u>Wellersburg</u>		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
62 <u>Sacred Heart Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>Howard F. Scell</u>				10 28 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	Divorced	January 17 1882	73 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Coal miner</u>		<u>Missouri</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John A. Scell</u>				<u>Mary Schumaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
<u>Robert W. Scell Wellersburg, Pa</u>				<u>Robert W. Scell Wellersburg, Pa</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				<u>Two years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-25-55</u> to <u>10-26-55</u> that I last saw the deceased alive on <u>10-27, 1955</u> and that death occurred at <u>7:15 AM</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>John A. Scell</u>				<u>10-28-55</u>			
M.D. <u>Cumberland, Md</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-31-55</u>		<u>100F cemetery</u>		<u>Lakewood Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 29, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>Harvey H. Leigler</u>		<u>Hydman Pa</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

MS-XISC 1-55 10M

00288

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU A. B.
OCT 1 1965

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS TO BE COMPLETED BY THE PHYSICIAN WHO HAS ATTENDED THE DECEASED OR BY THE PHYSICIAN WHO HAS BEEN CONSULTED IN CONNECTION WITH THE DEATH. IT IS TO BE COMPLETED IN THE PRESENCE OF TWO WITNESSES, ONE OF WHOM SHALL BE A MEMBER OF THE CLERGY OR A MEMBER OF THE COMMUNITY. IT IS TO BE COMPLETED IN THE PRESENCE OF TWO WITNESSES, ONE OF WHOM SHALL BE A MEMBER OF THE CLERGY OR A MEMBER OF THE COMMUNITY. IT IS TO BE COMPLETED IN THE PRESENCE OF TWO WITNESSES, ONE OF WHOM SHALL BE A MEMBER OF THE CLERGY OR A MEMBER OF THE COMMUNITY.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9299

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09289

Reg. Dist.

No. 9

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
<u>X</u> TOWN <u>Eckhart</u>		<u>6 yrs.</u>	TOWN <u>Eckhart</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # Frostburg, Md.</u>			STREET ADDRESS (If rural, give location) <u>R.F.D. # Frostburg, Md.</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
<u>Albert</u>	<u>Louis</u>	<u>Schaub</u>	<u>Oct.</u>	<u>9</u>	<u>19 55</u>
5. SEX:		6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:
<u>male</u>		<u>white</u>	<u>married</u>		<u>March 2-1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Laborer</u>		<u>Kelley-Springfield</u>		<u>48</u> yrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
<u>Frostburg, Md.</u>			<u>U.S.A.</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Louis Schaub</u>			<u>Euphemia Dunn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
<u>yes</u> <u>W.W.2.</u>			<u>214-07-0603</u>		
17. INFORMANT & ADDRESS:			<u>(wife) Emma Dick Schaub, Eckhart, Md.</u>		

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<p>241X</p> <p>Immediate cause (a)..... <u>Coronary occlusion</u>.....</p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b)..... <u>Coronary sclerosis also had</u>.....</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)..... <u>Bronchial asthma</u>.....</p>			<p><u>sudden</u></p> <p><u>?</u></p> <p><u>several</u></p> <p><u>years.</u></p>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE			
<u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct. 10-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR	
<u>Burial</u>		<u>Joseph R. Durst,</u>	
DATE REC'D BY LOCAL REG.		ADDRESS	
<u>10-13-55</u>		<u>Frostburg, Md.</u>	

BUREAU V. S.

OCT 17 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9263

CERTIFICATE OF DEATH

09290

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany CITY OR TOWN Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 Polk Street				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY Allegany CITY OR TOWN Cumberland STREET ADDRESS 113 Polk Street			
3. NAME OF DECEASED (Type or Print) Alexander F. Schute				4. DATE OF DEATH (Month) Oct (Day) 22 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec, 24.1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Guard		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. 214 07 0775		17. INFORMANT & ADDRESS Mrs. Ellen Schute (Wife)			
18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) myocardial failure ANTECEDENT CAUSE(S) DUE TO (B) myocardial infarction Recent. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic heart disease 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 6 mo. 20 yrs. 20 yrs.			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) None			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) None		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? None			
22. I hereby certify that I attended the deceased from Sept 9, 1955 , to Oct. 22, 1955 , that I last saw the deceased alive on Oct. 22, 1955 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE J. Hallinan MD		ADDRESS (Street, city, town, state) 140 Bedford St. Cumberland, MD		DATE SIGNED 10/24/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct, 25.1955		NAME OF CEMETERY OR CREMATORY St. Patricks cemetery.		LOCATION (City, town, or county) (State) Cumberland, MD.	
24. REC'D BY REGISTRAR Oct. 25, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing MD.			

CERTIFICATE OF DEATH

9309

DEPARTMENT OF HEALTH-BALTIMORE, MD

STATE OF MARYLAND

CITY OF BALTIMORE

WILLIAM J. BROWN

WHITE

DOB: 10-15-1900

RESIDENT OF BALTIMORE

DECEASED

DATE OF DEATH: 10-28-1955

PLACE OF DEATH: HOME

Cause of Death: HEART DISEASE

IMMEDIATE CAUSE: MYOCARDIAL INFARCTION

INTERMEDIATE CAUSE: HYPERTENSION

UNDERLYING CAUSE: ARTERIOSCLEROSIS

DATE OF REPORT: 10-29-1955

SIGNATURE OF REPORTER: J. B. BROWN

DATE OF SIGNATURE: 10-29-1955

PLACE OF SIGNATURE: BALTIMORE

STATE OF MARYLAND

CITY OF BALTIMORE

WILLIAM J. BROWN

WHITE

DOB: 10-15-1900

RESIDENT OF BALTIMORE

DECEASED

DATE OF DEATH: 10-28-1955

PLACE OF DEATH: HOME

Cause of Death: HEART DISEASE

IMMEDIATE CAUSE: MYOCARDIAL INFARCTION

INTERMEDIATE CAUSE: HYPERTENSION

UNDERLYING CAUSE: ARTERIOSCLEROSIS

DATE OF REPORT: 10-29-1955

SIGNATURE OF REPORTER: J. B. BROWN

DATE OF SIGNATURE: 10-29-1955

PLACE OF SIGNATURE: BALTIMORE

BUREAU V. 2

OCT 28 1955

RECEIVED

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09291

9285

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Ma</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		30 yrs.		TOWN <u>Frostburg</u>		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
000 <u>240 W. Mechanic St.</u>				<u>240 W. Mechanic St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>L.</u> (Last) <u>Short, Sr.</u>				10 17th 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	Married	4 - 29 - 1886	69 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Miner		Coal Mines		Rockwood, Pa.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Short				Nancy L. Lorrie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		1616 Elkins Lane, Mrs. Ivan White, Baltimore 30, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>177X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Prostate & metastasis</u>				1 yr -			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>generally throughout body</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 19, 55</u> , to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Oct 1, 1955</u> , and that death occurred at <u>7:10</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis, M.D.</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>10/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10 - 20-55		Porter Cemetery Eckhart		Eckhart Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-21-55</u>		<u>Mrs. Nancy N. Rie</u>		<u>Buriah H. Wontem</u>		<u>23 E. Main Frostburg, Md.</u>	

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Form 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

RECEIVED

RECEIVED

RECEIVED

BUREAU V. S.

RECEIVED

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

9264

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		32 DAYS		TOWN OLDTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL AVE.							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
MRS MARTHA A. SHRYOCK				OCT. 16 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	AUG. 29, 1897	58 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Ownhome		MARYLAND Frostburg		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OLIVER STEVENSON				SARAH DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
171X IMMEDIATE CAUSE (A)				Interval BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				3 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		Ca. of Cervix					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/1/55, 1955, to Oct 16, 1955, that I last saw the deceased alive on Oct 16, 1955, and that death occurred at 3:50PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
				Cumberland Md		10/17/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10-19-55		Davis Memorial		Cumberland, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 18, 1955		Walter R. Frantz, M.D.		James F. Scarpelli		Cumberland, Md.	

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

100-443887-100

BUREAU V. S.

5561 61 100

RECEIVED
JUN 10 1966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9300

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10365
Reg. 1951

No. 8

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Midland</u>		<u>4 1/2</u> years		TOWN <u>Midland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dans Rock Road</u>				STREET ADDRESS (If rural, give location) <u>Dans Rock Road.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Clarence Lynn Sires</u>				<u>Oct. 31 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)? <u>married</u>		8. DATE OF BIRTH: <u>Feb. 18-1892</u>	
9. AGE last birthday: <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life. If retired, so state): <u>Tire Inspector Kelley-S. Tire Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Graham Town, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Sires</u>				14. MOTHER'S MAIDEN NAME: <u>Hester Tomlinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>214-07-0587</u>		17. INFORMANT & ADDRESS: <u>(wife) Effie Sires, Midland, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) <u>Coronary sclerosis with angina syndrome</u> Diseases or conditions, if any, giving rise to the above cause (b) <u>stating underlying cause last</u> stating underlying cause last (c)						<u>sudden</u> <u>1 yr.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D. H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Oct. 31-1955</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Nov. 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Vale Summit Cemetery, Vale Summit, MD.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>11-2-55</u>		REGISTRAR'S SIGNATURE <u>Janette M. Pool</u>		24. FUNERAL DIRECTOR <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

BUREAU V. S.

NOV 9 1953

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09293

9301

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural, Oldtown</u>		LENGTH OF STAY (In this place) <u>53 Yrs</u>		TOWN <u>Rural, Oldtown</u>		TOWN <u>Rural, Oldtown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1, Oldtown</u>				STREET ADDRESS (If rural give location) <u>Rt. 1, Oldtown</u>			
3. NAME OF DECEASED (Type or Print) <u>MARTHA CARRIE HITE SNYDER</u>				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>7</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 6, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE FRANCIS HITE</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Pinkney Snyder, Green Ridge Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>199-1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Neoplasm, atobionous Nk 3 yrs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-11-55</u> to <u>9-11-55</u> that I last saw the deceased alive on <u>9-11-55</u> and that death occurred at <u>10-8-55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Armstrong</u>				DATE SIGNED <u>10-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Mem. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Allegany County, Md.</u>	
24. REC'D BY REGISTRAR <u>Oct. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. Fay Buckworth</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

18-000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

REGISTRATION NO.

1. LOCAL HEALTH DEPARTMENT OR DISTRICT

2. PLACE OF DEATH

3. NAME

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE

10. TIME

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. SEX

14. OCCUPATION

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. DATE

18. TIME

19. PLACE OF BIRTH

20. DATE OF BIRTH

21. SEX

22. OCCUPATION

23. CAUSE OF DEATH

24. MANNER OF DEATH

25. DATE

26. TIME

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX

30. OCCUPATION

31. CAUSE OF DEATH

32. MANNER OF DEATH

33. DATE

34. TIME

35. PLACE OF BIRTH

36. DATE OF BIRTH

37. SEX

38. OCCUPATION

39. CAUSE OF DEATH

40. MANNER OF DEATH

41. DATE

42. TIME

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. SEX

46. OCCUPATION

47. CAUSE OF DEATH

48. MANNER OF DEATH

49. DATE

50. TIME

51. PLACE OF BIRTH

52. DATE OF BIRTH

53. SEX

54. OCCUPATION

55. CAUSE OF DEATH

56. MANNER OF DEATH

57. DATE

58. TIME

59. PLACE OF BIRTH

60. DATE OF BIRTH

61. SEX

62. OCCUPATION

63. CAUSE OF DEATH

64. MANNER OF DEATH

65. DATE

66. TIME

67. PLACE OF BIRTH

68. DATE OF BIRTH

69. SEX

70. OCCUPATION

71. CAUSE OF DEATH

72. MANNER OF DEATH

73. DATE

74. TIME

75. PLACE OF BIRTH

76. DATE OF BIRTH

77. SEX

78. OCCUPATION

79. CAUSE OF DEATH

80. MANNER OF DEATH

81. DATE

82. TIME

83. PLACE OF BIRTH

84. DATE OF BIRTH

85. SEX

86. OCCUPATION

87. CAUSE OF DEATH

88. MANNER OF DEATH

89. DATE

90. TIME

91. PLACE OF BIRTH

92. DATE OF BIRTH

93. SEX

94. OCCUPATION

95. CAUSE OF DEATH

96. MANNER OF DEATH

97. DATE

98. TIME

99. PLACE OF BIRTH

100. DATE OF BIRTH

101. SEX

102. OCCUPATION

103. CAUSE OF DEATH

104. MANNER OF DEATH

105. DATE

106. TIME

107. PLACE OF BIRTH

108. DATE OF BIRTH

109. SEX

110. OCCUPATION

111. CAUSE OF DEATH

112. MANNER OF DEATH

113. DATE

114. TIME

115. PLACE OF BIRTH

116. DATE OF BIRTH

117. SEX

118. OCCUPATION

119. CAUSE OF DEATH

120. MANNER OF DEATH

121. DATE

122. TIME

123. PLACE OF BIRTH

124. DATE OF BIRTH

125. SEX

126. OCCUPATION

127. CAUSE OF DEATH

128. MANNER OF DEATH

129. DATE

130. TIME

131. PLACE OF BIRTH

132. DATE OF BIRTH

133. SEX

134. OCCUPATION

135. CAUSE OF DEATH

136. MANNER OF DEATH

137. DATE

138. TIME

139. PLACE OF BIRTH

140. DATE OF BIRTH

141. SEX

142. OCCUPATION

143. CAUSE OF DEATH

144. MANNER OF DEATH

145. DATE

146. TIME

147. PLACE OF BIRTH

148. DATE OF BIRTH

149. SEX

150. OCCUPATION

151. CAUSE OF DEATH

152. MANNER OF DEATH

153. DATE

154. TIME

155. PLACE OF BIRTH

156. DATE OF BIRTH

157. SEX

158. OCCUPATION

159. CAUSE OF DEATH

160. MANNER OF DEATH

161. DATE

162. TIME

163. PLACE OF BIRTH

164. DATE OF BIRTH

165. SEX

166. OCCUPATION

167. CAUSE OF DEATH

168. MANNER OF DEATH

169. DATE

170. TIME

It is a pleasure to sign this certificate

BUREAU V. S.

OCT 13 1935

RECEIVED

W. H. B. Smith
1110 1st St. N.W.
Washington, D.C.

20-11-10-10-10

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

9302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09224^{ist.}

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Rural LaVale</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Frostburg</u>	<u>22</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Cumberland Highway # 40</u>		STREET ADDRESS (If rural, give location) <u>79 Spring St.</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Francis X. Spearman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 19 19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Jan. 26-1896</u>
9. AGE last birthday: <u>59</u> yrs.		10. DATE OF BIRTH: <u>Jan. 26-1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Diver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B&O R.R.</u>	
11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Andrew Spearman</u>		14. MOTHER'S MAIDEN NAME: <u>Rose Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>705-05-8069</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>(wife) Cathaline Spearman, Frostburg, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
816X Immediate cause (a) <u>Exsanguination due to a crushed skull</u> DUE TO			<u>sudden</u>
Antecedent cause(s) (b) <u>Mutilation of body, fractured limbs also arms</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>head and part of body burned.</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>Oct. 19-1955</u>			19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office, bldg., etc.) <u>Highway 40</u>	21c. (City or town) (County) (State) <u>LaVale Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 19-1955 A. M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Run-a-Way Tractor trailer ran into automobile.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>Oct. 19-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Oct. 22-1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>	LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
DATE REC'D BY LOCAL REG. <u>Oct. 21, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>	24. FUNERAL DIRECTOR ADDRESS <u>J.R. Durst Funeral Home, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK.—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 24 1955

BUREAU V. S.

With a corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9265

CERTIFICATE OF DEATH

09295

Reg. Dist. No. 4

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
V5 A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		STATE W. VA.		COUNTY MINERAL	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 8 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KEYSER		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 119 CENTRE ST.			
3. NAME OF DECEASED (First) MARY (Middle) IRENE (Last) STEMPLE				4. DATE OF DEATH (Month) OCT. (Day) 16, (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JULY 15, 1901		9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY STATE ROADS COMM. W. VA.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME HENRY C. STEMPLE				14. MOTHER'S MAIDEN NAME ANNA C. SHIRCLIFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 236-50-8804		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
172X IMMEDIATE CAUSE (A) Carcinoma						uterus	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 3-9-53		19b. MAJOR FINDINGS OF OPERATION Carcinoma fundus uterus				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, Yerm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-8 1955 to 10-16 1955 , that I last saw the deceased alive on 10-15 1955 , and that death occurred at 7:03 A.M. from the causes and on the date stated above.							
SIGNATURE Howard P. Tolson				ADDRESS (Street, city, town, state)		DATE SIGNED 10-17-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 18, 1955		NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		LOCATION (City, town, or county) (State) Oakland, Maryland.	
24. REG'D BY REGISTRAR Oct. 17, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, West Virginia			

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1935

DATE OF DEATH

HEALTH DEPARTMENT, BALTIMORE, MD.

MINERAL

KEYSER

119 CENTRAL ST.

ALLIANCE

CORRECTIONAL

WESTLAND STATE HOSPITAL

MARY

STEPHENS

WOMAN

FEMALE WHITE

WHITE

JULY 15, 1901

HUSBAND

STATE ROAD CO. N. Y.

CLERK

HENRY C. STEPHENS

WOMAN OF DISCHARGE

HEALTH DEPARTMENT, BALTIMORE, MD.

34-50-1004

WESTLAND STATE HOSPITAL

BUREAU V. 2

OCT 18 1935

RECEIVED

NOTIFICATION

IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO NOTIFY THE NEAREST RELATIVE OF THE DECEASED OF THE DEATH AND TO OBTAIN A SIGNATURE OF THE NEAREST RELATIVE TO THE CERTIFICATE OF DEATH. IF THE DECEASED WAS A MEMBER OF A RELIGIOUS CHURCH, THE PASTOR OF THE CHURCH SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A LABOR UNION, THE SECRETARY OF THE UNION SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A VETERAN'S ORGANIZATION, THE NATIONAL COMMISSIONER OF THE ORGANIZATION SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A MILITARY ORGANIZATION, THE SECRETARY OF THE ORGANIZATION SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A FIRE DEPARTMENT, THE CHIEF OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A POLICE DEPARTMENT, THE CHIEF OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A NAVY OR ARMY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A MARINE CORPS, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A COAST GUARD, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A CUSTOMS SERVICE, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A POST OFFICE, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A RAILROAD, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A STEAMSHIP COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A TRUCKING COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A BUS COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A TAXI COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A RENTAL CAR COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A TRUCKING COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A BUS COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A TAXI COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED. IF THE DECEASED WAS A MEMBER OF A RENTAL CAR COMPANY, THE SECRETARY OF THE DEPARTMENT SHOULD BE NOTIFIED.

Outside of
City Limits

9303
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09296
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN (rural) <u>Cumberland</u>		<u>26 yrs.</u>		TOWN (rural) <u>Cumberland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#3 Bedford Road.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D.#3 Bedford Road.</u>			
3. NAME OF DECEASED: (First) <u>Luther</u>		(Middle) <u>Stine</u>		(Last)		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>2</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>May 16-1887</u>		9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Contractor</u>		11. BIRTHPLACE (State or foreign country): <u>Star Tannery, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W. Stine</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Brill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>R.F.D.#3 Md.</u>		(wife) <u>Ada Bradfield Stine, Cumberland,</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) <u>Coronary thrombosis</u>		DUE TO		(about) <u>3 months</u>	
Antecedent cause(s) (b) <u>Coronary sclerosis</u>		DUE TO		<u>7 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>Oct. 2-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Oct. 5, 1955</u>		<u>Hillcrest Cemetery, Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Oct. 4, 1955</u>		<u>Walter K. Trout, M.D.</u>		<u>William A. Light, " "</u>	

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 5 1955

BUREAU V. 1

No.

J.R.Durst Funeral Home, Frostburg, Md.

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 24 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09298

9315 CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lonaconing</u>				TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Rockville Street</u>				<u>Rockville Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William Thomas</u>				<u>Oct, 11 1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Sept, 14. 1890</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>65</u> yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Coal Miner</u>						<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Thomas</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>217-05-5745</u>		<u>Mr. Stanley Thomas (SON)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Lonaconing, MD.</u>			
IMMEDIATE CAUSE (A)				<u>Carcinoma of Pancreas</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>to Metastases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>9 mo.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>mar 1955</u>		<u>Cad Pancreas</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953 (July 19)</u> to <u>11 Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11 Oct</u> , 19 <u>55</u> , and that death occurred at <u>5:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Dr. Richard</u>				<u>Lonaconing</u>		<u>10-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct, 13. 1955</u>		<u>Laurel Hill Cemetery.</u>		<u>Moscow, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-14-55</u>		<u>Janette M Boal</u>		<u>George Eichhorn, Lonaconing, MD.</u>			

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD. 00233

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. NAME OF DECEASED	
Baltimore		William	
3. STREET		4. CITY	
Cockville Street		Baltimore	
5. HOUSE NO.		6. DATE OF DEATH	
100		April 10, 1900	
7. SEX		8. AGE	
Male		35	
9. OCCUPATION		10. CAUSE OF DEATH	
Clerk		Typhoid Fever	
11. PLACE OF BIRTH		12. DATE OF BIRTH	
Maryland		April 10, 1865	
13. NAME OF PHYSICIAN		14. NAME OF BURIAL PLACE	
Dr. J. H. Smith		St. Mary's Cemetery	
15. NAME OF FUNERAL HOME		16. NAME OF MINISTER	
None		Rev. J. H. Smith	
17. NAME OF WITNESS		18. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
19. NAME OF WITNESS		20. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
21. NAME OF WITNESS		22. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
23. NAME OF WITNESS		24. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
25. NAME OF WITNESS		26. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
27. NAME OF WITNESS		28. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
29. NAME OF WITNESS		30. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
31. NAME OF WITNESS		32. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
33. NAME OF WITNESS		34. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
35. NAME OF WITNESS		36. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
37. NAME OF WITNESS		38. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
39. NAME OF WITNESS		40. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
41. NAME OF WITNESS		42. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
43. NAME OF WITNESS		44. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
45. NAME OF WITNESS		46. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
47. NAME OF WITNESS		48. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
49. NAME OF WITNESS		50. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
51. NAME OF WITNESS		52. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
53. NAME OF WITNESS		54. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
55. NAME OF WITNESS		56. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
57. NAME OF WITNESS		58. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
59. NAME OF WITNESS		60. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
61. NAME OF WITNESS		62. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
63. NAME OF WITNESS		64. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
65. NAME OF WITNESS		66. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
67. NAME OF WITNESS		68. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
69. NAME OF WITNESS		70. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
71. NAME OF WITNESS		72. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
73. NAME OF WITNESS		74. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
75. NAME OF WITNESS		76. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
77. NAME OF WITNESS		78. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
79. NAME OF WITNESS		80. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
81. NAME OF WITNESS		82. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
83. NAME OF WITNESS		84. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
85. NAME OF WITNESS		86. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
87. NAME OF WITNESS		88. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
89. NAME OF WITNESS		90. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
91. NAME OF WITNESS		92. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
93. NAME OF WITNESS		94. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
95. NAME OF WITNESS		96. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
97. NAME OF WITNESS		98. NAME OF WITNESS	
J. H. Smith		J. H. Smith	
99. NAME OF WITNESS		100. NAME OF WITNESS	
J. H. Smith		J. H. Smith	

BUREAU V. 8

APR 17 1900

RECEIVED

George E. Smith, Secretary, Baltimore, Md.

NOTICE: This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Md. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the attending physician or the coroner. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the attending physician or the coroner.

VS A15C 1-55 10M

9266

CERTIFICATE OF DEATH

09299

Reg. Dist. No. 7

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY	MARYLAND	STATE MARYLAND	COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND	LENGTH OF STAY (In this place) 63 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,	02
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS (If rural give location) 317 FIFTH STREET	1
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) WILLIAM	(Middle) P	(Last) TWIGG	(Month) 10 (Day) 17 (Year) 19 55
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 16
9. AGE last birthday 81 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Foreman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (State or foreign country) W.VA. Doe Gully Tunnel
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HARMAN TWIGG		14. MOTHER'S MAIDEN NAME MARY HUDSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-09-7023	
		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Cerebral Thrombosis		16 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Art Sch Co. LD.		5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/14/55 , 19_____, to 10/17/55 , 19_____, that I last saw the deceased alive on 10/14/55 , 19_____, and that death occurred at 8:45AM , from the causes and on the date stated above.			
SIGNATURE W. B. ...		ADDRESS (Street, city, town, state) W. B. ... Cumberland Md	
DATE SIGNED 10/19/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 20, 1955	
NAME OF CEMETERY OR CREMATORY Davis Mem. Cemetery		LOCATION (City, town, or county) (State) Allegany County, Md.	
24. REC'D BY REGISTRAR W. B. ...		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer,	
REGISTRAR'S SIGNATURE W. B. ...		ADDRESS Cumberland, Maryland	

RECEIVED

1
Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09300

9267 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>326 Cumberland Street</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> STREET ADDRESS (If rural give location) <u>326 Cumberland Street</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY HILDA VOCKE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 5, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 4, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Vale Summit, Allegany Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HEALY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET MALLON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>326 Cumberland St. Margaret Vocke, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) Myocardial Degeneration</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arteriosclerosis, generalized</u> (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>10/5</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>9/15</u> , 19 <u>55</u> , to <u>10/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. H. L. Lenz Jr.</u>		M.D. <u>422 N. Centre St. Cumberland</u>		DATE SIGNED <u>10/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STS. Peter & Paul Cem. Cumberland, Maryland</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Oct. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Kautz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

00300

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

0387

Birth Date: 11/11

1. DEATH INFORMATION (NAME OF DECEASED)

MARYLAND

CITY OF BALTIMORE

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

ST. JAMES

Physician's Signature
Dr. J. M. Smith

BUREAU V. 8

OCT 11 1953

RECEIVED

10/11/53

10/11/53

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased.
2. The information on this form is used for statistical purposes only and is not to be used for legal purposes.
3. The information on this form is to be filled out as completely as possible.
4. The information on this form is to be filled out as accurately as possible.
5. The information on this form is to be filled out as honestly as possible.
6. The information on this form is to be filled out as truthfully as possible.
7. The information on this form is to be filled out as fairly as possible.
8. The information on this form is to be filled out as justly as possible.
9. The information on this form is to be filled out as lawfully as possible.
10. The information on this form is to be filled out as ethically as possible.

9268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALEEGANY		MARYLAND		STATE PENNA.		COUNTY SOMERSET	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		9 DAYS		TOWN MEYERSDALE, RURAL		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES				RT. #3			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
OLIVE P. WAHL				OCT. 8 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	MARCH 11, 1906	49 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		PENNA.		American	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CALVIN L. GEIGER				THERESA HARDING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
N				Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
581.0 IMMEDIATE CAUSE (A)				Emphysema of Liver		3-4 yrs	
ANTECEDENT CAUSE(S) DUE TO				Abdominal ascites		2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
Sept 30, 54				Abdominal		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 5, 1955, to June 5, 1955, that I last saw the deceased alive on Oct 7, 1955, and that death occurred at 4:50 A.M. from the causes and on the date stated above.							
SIGNATURE W.T. Hodges				DATE SIGNED 10/8/55			
M.D. Cumberland, Md				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct 11, 55		Union Cemetery		Meyersdale Pa. Somers	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 10, 1955		Walter R. Hantz, M.D.		William R. Hantz, M.D.		Meyersdale Pa	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3508

Reg. No. 125

1. DATE OF DEATH: OCT. 1, 1955

2. TIME OF DEATH: 10:00 AM

3. PLACE OF DEATH: HOME

4. NAME OF DECEASED: JAMES H. HARRIS

5. SEX: MALE

6. AGE: 68

7. RACE: WHITE

8. OCCUPATION: RETIRED

9. MARITAL STATUS: MARRIED

10. CAUSE OF DEATH: HEART DISEASE

11. MANNER OF DEATH: NATURAL

12. SIGNATURE OF PHYSICIAN: J. H. HARRIS

13. SIGNATURE OF REGISTRAR: J. H. HARRIS

14. SIGNATURE OF WITNESS: J. H. HARRIS

15. SIGNATURE OF DECEASED: J. H. HARRIS

16. SIGNATURE OF NEXT OF KIN: J. H. HARRIS

17. SIGNATURE OF CLERK: J. H. HARRIS

18. SIGNATURE OF CHURCH CLERK: J. H. HARRIS

19. SIGNATURE OF BURIAL CLERK: J. H. HARRIS

20. SIGNATURE OF OTHER: J. H. HARRIS

21. SIGNATURE OF OTHER: J. H. HARRIS

22. SIGNATURE OF OTHER: J. H. HARRIS

23. SIGNATURE OF OTHER: J. H. HARRIS

24. SIGNATURE OF OTHER: J. H. HARRIS

25. SIGNATURE OF OTHER: J. H. HARRIS

26. SIGNATURE OF OTHER: J. H. HARRIS

27. SIGNATURE OF OTHER: J. H. HARRIS

28. SIGNATURE OF OTHER: J. H. HARRIS

29. SIGNATURE OF OTHER: J. H. HARRIS

30. SIGNATURE OF OTHER: J. H. HARRIS

1. DATE OF DEATH: OCT. 1, 1955

2. TIME OF DEATH: 10:00 AM

3. PLACE OF DEATH: HOME

4. NAME OF DECEASED: JAMES H. HARRIS

5. SEX: MALE

6. AGE: 68

7. RACE: WHITE

8. OCCUPATION: RETIRED

9. MARITAL STATUS: MARRIED

10. CAUSE OF DEATH: HEART DISEASE

11. MANNER OF DEATH: NATURAL

12. SIGNATURE OF PHYSICIAN: J. H. HARRIS

13. SIGNATURE OF REGISTRAR: J. H. HARRIS

14. SIGNATURE OF WITNESS: J. H. HARRIS

15. SIGNATURE OF DECEASED: J. H. HARRIS

16. SIGNATURE OF NEXT OF KIN: J. H. HARRIS

17. SIGNATURE OF CLERK: J. H. HARRIS

18. SIGNATURE OF CHURCH CLERK: J. H. HARRIS

19. SIGNATURE OF BURIAL CLERK: J. H. HARRIS

20. SIGNATURE OF OTHER: J. H. HARRIS

21. SIGNATURE OF OTHER: J. H. HARRIS

22. SIGNATURE OF OTHER: J. H. HARRIS

23. SIGNATURE OF OTHER: J. H. HARRIS

24. SIGNATURE OF OTHER: J. H. HARRIS

25. SIGNATURE OF OTHER: J. H. HARRIS

26. SIGNATURE OF OTHER: J. H. HARRIS

27. SIGNATURE OF OTHER: J. H. HARRIS

28. SIGNATURE OF OTHER: J. H. HARRIS

29. SIGNATURE OF OTHER: J. H. HARRIS

30. SIGNATURE OF OTHER: J. H. HARRIS

1. DATE OF DEATH: OCT. 1, 1955

2. TIME OF DEATH: 10:00 AM

3. PLACE OF DEATH: HOME

4. NAME OF DECEASED: JAMES H. HARRIS

5. SEX: MALE

6. AGE: 68

7. RACE: WHITE

8. OCCUPATION: RETIRED

9. MARITAL STATUS: MARRIED

10. CAUSE OF DEATH: HEART DISEASE

11. MANNER OF DEATH: NATURAL

12. SIGNATURE OF PHYSICIAN: J. H. HARRIS

13. SIGNATURE OF REGISTRAR: J. H. HARRIS

14. SIGNATURE OF WITNESS: J. H. HARRIS

15. SIGNATURE OF DECEASED: J. H. HARRIS

16. SIGNATURE OF NEXT OF KIN: J. H. HARRIS

17. SIGNATURE OF CLERK: J. H. HARRIS

18. SIGNATURE OF CHURCH CLERK: J. H. HARRIS

19. SIGNATURE OF BURIAL CLERK: J. H. HARRIS

20. SIGNATURE OF OTHER: J. H. HARRIS

21. SIGNATURE OF OTHER: J. H. HARRIS

22. SIGNATURE OF OTHER: J. H. HARRIS

23. SIGNATURE OF OTHER: J. H. HARRIS

24. SIGNATURE OF OTHER: J. H. HARRIS

25. SIGNATURE OF OTHER: J. H. HARRIS

26. SIGNATURE OF OTHER: J. H. HARRIS

27. SIGNATURE OF OTHER: J. H. HARRIS

28. SIGNATURE OF OTHER: J. H. HARRIS

29. SIGNATURE OF OTHER: J. H. HARRIS

30. SIGNATURE OF OTHER: J. H. HARRIS

BUREAU V. 8

OCT 11 1955

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09302

9286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg, Md.</u>		<u>1 day</u>		TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>104 Ormand</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lillie</u> <u>Wasmuth</u>				<u>October 15, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Single</u>	<u>5-14-1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>School Teacher Elementary School</u>			<u>Washington, D.C.</u>		<u>U.S.A.</u>		
13. FATHER'S NAME <u>Eckhart Wasmuth</u>				14. MOTHER'S MAIDEN NAME <u>Christine Tilp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> <u>None</u>		<u>None</u>		<u>Frostburg, Md.</u> <u>Charles Harbel, Sr. 171 E. Main</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>442X</u> <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>One week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular renal disease</u>						<u>One month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 4, 1955</u> , to <u>Oct. 15, 1955</u> , that I last saw the deceased alive on <u>Oct. 14, 1955</u> , and that death occurred at <u>4:53 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Silda Jurelka</u>				ADDRESS (Street, city, town, state) <u>48 Broadway, Frostburg, Md.</u> DATE SIGNED <u>Oct. 15, 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/17/55</u>		<u>Frostburg Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>10-20-55</u>		<u>Nancy N. Rice</u>		<u>23 E. Main</u> <u>Frostburg, Md.</u>			

10303

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

10303

1. DECEASED PERSON'S NAME OR RELATION

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SEX

12. RACE

13. AGE

14. DATE OF DEATH

15. TIME OF DEATH

16. PLACE OF DEATH

17. CAUSE OF DEATH

18. MANNER OF DEATH

19. SEX

20. RACE

21. AGE

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF DEATH

25. CAUSE OF DEATH

26. MANNER OF DEATH

27. SEX

28. RACE

29. AGE

30. DATE OF DEATH

31. TIME OF DEATH

32. PLACE OF DEATH

33. CAUSE OF DEATH

34. MANNER OF DEATH

35. SEX

36. RACE

37. AGE

38. DATE OF DEATH

39. TIME OF DEATH

40. PLACE OF DEATH

41. CAUSE OF DEATH

42. MANNER OF DEATH

43. SEX

44. RACE

45. AGE

46. DATE OF DEATH

47. TIME OF DEATH

48. PLACE OF DEATH

49. CAUSE OF DEATH

50. MANNER OF DEATH

51. SEX

52. RACE

53. AGE

54. DATE OF DEATH

55. TIME OF DEATH

56. PLACE OF DEATH

57. CAUSE OF DEATH

58. MANNER OF DEATH

BUREAU V. 2

OCT 24 1955

RECEIVED

RECEIVED
OCT 24 1955
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Cumberland LENGTH OF STAY (in this place)
20 minutesHOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY AlleganyCITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN CumberlandSTREET ADDRESS (If rural, give location)
523 Old Town Road.3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) Mary Elizabeth McKenzie Wempe4. DATE OF DEATH (Month) (Day) (Year)
Oct. 21 19 555. SEX: Female 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 8. DATE OF BIRTH: Dec. 22-18849. AGE last birthday: 70 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife 10b. KIND OF BUSINESS OR INDUSTRY: Own home11. BIRTHPLACE (State or foreign country): Allegany Co. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.13. FATHER'S NAME:
Nicholas A. McKenzie14. MOTHER'S MAIDEN NAME:
Marion A. Miller15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no16. SOCIAL SECURITY No.: none17. INFORMANT & ADDRESS:
(sister) Jo Ann McKenzie, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Chronic myocarditis also had a large colloid goiter and incarcerated umbilical hernia.

(c)

INTERVAL BETWEEN ONSET AND DEATH
sudden several years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.
SIGNATUREH.V. Deming M.D.CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Oct. 21-1955
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial Oct. 24, 1955 St. Peter and Pauls Cem. Cumberland, Maryland
Oct. 23, 1955 Walter A. Frank, M.D. Louis Stern, Inc.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 25 1963
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLANDCITY (If outside corporate limits, write RURAL and give nearest town) OR 12 TOWN Cumberland LENGTH OF STAY (in this place) 4 daysHOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY AlleganyCITY (If outside corporate limits write RURAL and give nearest town) OR 02 TOWN CumberlandSTREET ADDRESS (If rural, give location) 127 Humbird St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Walter Ivan Whetzel

4. DATE OF DEATH

(Month)

(Day)

(Year)

Oct. 25 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.male whitemarriedSept. 16-190154 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, (even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Projection operatorGarden TheaterLost River, W. Va.U.S.A.

13. FATHER'S NAME:

(Unknown)Whetzel

14. MOTHER'S MAIDEN NAME:

Nora Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

214-05-4425

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

976X

Immediate cause

DUE TO

(a) Intracranial hemorrhage due to a 32 caliber

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(b) revolver wound in right temporal region(c) lodged in left parietal lobe, self inflicted.INTERVAL BETWEEN ONSET AND DEATH
4 days

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Coronary occlusion5-7 days.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town)

(County)

(State)

Cumberland Allegany Md.21d. TIME (Month) (Day) (Year) (Hour) OF INJURY about 4 P. M.21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Despondent and shot himself.22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

M. D. CHIEF MEDICAL EXAMINER

DATE SIGNED Oct. 25-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialOct. 28, 1955Springfield CemeterySpringfield, West VirginiaW. Va.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct. 26, 1955Walter R. Hantz, M.D.Charles L. GeorgeCumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 27 1955

BUREAU V. S.

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9271

CERTIFICATE OF DEATH

09305

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		5 DAYS		Near CUMBERLAND, rural		x	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS		RT. #2, WILLIAMS ROAD	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN (Middle) N. (Last) WHITNEY				(Month) OCT. (Day) 16. (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
MALE	WHITE	WIDOWED	DEC. 25, 1899	55 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CARPENTER		self emp.		WEST VIRGINIA Allensville		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN F. WHITNEY				PHOEBE MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
11		705-07-8970		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						420.1	
IMMEDIATE CAUSE (A) Coronary Thrombosis						Acute	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						Myocarditis - Leucopenic	
STATING UNDERLYING CAUSE LAST, DUE TO						6 wks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
6						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Sept 15, 19 55, to Oct 16, 19 55, that I last saw the deceased alive on Oct 16, 19 55, and that death occurred at 12:10 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Clayton L. Linn				Cumberland		9/17/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		10-19-55		Hillcrest Burial Park		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		Winter R. Lantz, M.D.		James F. Scarpelli		Cumberland, Md.	

THE UNIVERSITY OF CHICAGO
 LIBRARY
 540 EAST 58TH STREET
 CHICAGO, ILL. 60637
 TEL: 773-936-5000
 FAX: 773-936-5000
 WWW: WWW.CHICAGO.EDU

RECEIVED
OCT 19 1955

BUREAU V. 5

OCT 19 1955

9272

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR end give nearest town) 02 TOWN Cumberland		LENGTH OF STAY (in this place) 7/29/53		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary				STREET ADDRESS (If rural give location) 322 Pennsylvania Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Sylvia (Middle) (Last) Whitt				(Month) (Day) (Year) October 8, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 10/23/1886	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Yost				14. MOTHER'S MAIDEN NAME Sarah Rudolph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) Pulmonary Hypostasis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Hepatitis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Arteriosclerosis				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. osteo - arthritis				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 29, 1953 to Oct. 8, 1955 , that I last saw the deceased alive on Oct. 7, 1955 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
SIGNATURE James E. McLean M.D.				ADDRESS (Street, city, town, state) 49 Greene St		DATE SIGNED 10/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 10, 1955		NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		LOCATION (City, town, or county) (State) Keyser, West Virginia	
24. REC'D BY REGISTRAR Oct. 10, 1955		REGISTRAR'S SIGNATURE Walter A. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Roger's Funeral Home, Keyser, West Virginia			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESSES

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESSES

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF DECEASED

24. SIGNATURE OF WITNESSES

BUREAU V. 3

OCT 17 1955

RECEIVED

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09307

9376

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allwgary</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>----</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Harold</u> <u>Wilson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct.</u> <u>3rd.</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 5th. 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Park</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6569</u>		17. INFORMANT & ADDRESS <u>Miss Marion Wilson, Midland, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)			
IMMEDIATE CAUSE (A) <u>Sarcoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 YRS. ??</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>FEB. 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>SARCOMA</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB.</u> , 19 <u>55</u> , to <u>10/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/3</u> , 19 <u>55</u> , and that death occurred at <u>2:00 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Marion St. Eiguo</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Broadway - Frostburg Md. 10/1/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct. 6th. 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>10-6-55</u>		REGISTRAR'S SIGNATURE <u>Januette M. Boal</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

THE PHOTODUPLICATION SERVICE OF THE NATIONAL ARCHIVES IS AVAILABLE TO THE PUBLIC FOR THE REPRODUCTION OF DOCUMENTS IN THE NATIONAL ARCHIVES COLLECTION. THE SERVICE IS AVAILABLE TO THE PUBLIC FOR THE REPRODUCTION OF DOCUMENTS IN THE NATIONAL ARCHIVES COLLECTION. THE SERVICE IS AVAILABLE TO THE PUBLIC FOR THE REPRODUCTION OF DOCUMENTS IN THE NATIONAL ARCHIVES COLLECTION.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

00000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

TO DEATH

TIME

PLACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

BUREAU V. 2

Oct 19 1955

RECEIVED

Source: National Archives, RG 226, Entry 100, Box 100, Folder 100, Subfolder 100, Item 100

09308

9273

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland TOWN Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland TOWN Cumberland STREET ADDRESS (If rural give location) 111 Maple Street			
3. NAME OF DECEASED (First) Peter (Middle) Yanezich (Last) Yanezich				4. DATE OF DEATH (Month) October (Day) 25 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6/21/1883	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - R.R. - Ties Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Yanezich				14. MOTHER'S MAIDEN NAME Miriam Garul			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) Chronic Myocarditis						?	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Chronic Nephritis						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Secondary Anemia						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 20, 1954 , to Oct 25, 1955 , that I last saw the deceased alive on Oct. 25, 1955 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
SIGNATURE James E. McLean		M.D.		ADDRESS (Street, city, town, state) 47 Greene St. Cumberland, Md.		DATE SIGNED Oct. 26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10-29-55	NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		LOCATION (City, town, or county) (State) Cumberland, Md.			
24. REC'D BY REGISTRAR Oct. 29, 1955	REGISTRAR'S SIGNATURE Winter R. Freutz, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

80308

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
George Washington		62/1/1900		Male		White		Caucasian	
Date of Death		Place of Death		Cause of Death		Disease		Manner of Death	
October 25, 1955		Baltimore, Md.		Heart Disease		Coronary Artery Disease		Natural	
Time of Death		Physician		Hospital		Burial Place		Burial Date	
10:30 AM		J. Edgar Smith, M.D.		St. Mary's Hospital		St. Mary's Cemetery		October 26, 1955	
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Witness		Signature of Deceased	
J. Edgar Smith		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

BUREAU V. E.

RECEIVED
NOV 2 1955

RECORDED
INDEXED
FBI - BALTIMORE
OCT 27 1955
100-100000-100000

9274 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>15 Mins.</u>		CITY OR TOWN <u>Cresaptown, Md</u>		CITY OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Dispensary</u>		STREET ADDRESS <u>Rt. 220</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Riley</u>		(Middle) <u>Hess</u>		(Last) <u>Yokum</u>		(Month) <u>Oct.</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 18, 1890</u>	
9. AGE last birthday <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery store</u>		11. BIRTHPLACE (State or foreign country) <u>Red Creek, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Yokum</u>				14. MOTHER'S MAIDEN NAME <u>Anna Flanagan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-8382</u>		17. INFORMANT & ADDRESS <u>Mrs Riley Yokum, Cresaptown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Cardiac Tamponade</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Heart Disease</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatoid arthritis</u>						<u>18 mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-14-54</u> , 19 <u>54</u> , to <u>10-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-18</u> , 19 <u>55</u> , and that death occurred at <u>10:10 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Deane W. Baeris</u>		ADDRESS (Street, city, town, state) <u>62 Greene St Cumberland Md</u>		DATE SIGNED <u>10-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>Oct. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 11

RECEIVED

EMOITCUEM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH: 9275				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Allegany		MARYLAND		STATE Md.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN Cumberland		35 Yrs.		TOWN Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.				STREET ADDRESS (If rural, give location) 110 Springdale St.			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
John		Washington		Youngblood		4. DATE OF DEATH	
						Oct. 23 19 55	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Male		white		married		Oct. 10-1887	
9. AGE last birthday:		yrs.		68		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	
						Carmen	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Martinsburg, W. Va.		U.S.A.		Adam Youngblood		Louise Elizabeth Wharton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		705-05-8552		(wife) Myrtle Light Youngblood, City.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary Occlusion						sudden	
DUE TO Antecedent cause(s) (b) Coronary sclerosis						?	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		H.V. Deming M.D.		H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER	
						DEPUTY MEDICAL EXAMINER	
						ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 26, 1955		Hillcrest Burial Park, Cumberland, Maryland			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct. 25, 1955		Walter R. Trautz, M.D.		James F. Scarpelli, "		"	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

OCT 28 1921

RECEIVED

1
Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09311

9276

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		7 DAYS		TOWN NEAR CUMBERLAND, rural		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
60 MEMORIAL HOSPITAL				RT. #2 BALTIMORE PIKE			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
MRS. HELEN		E. Young KERTONKERS		OCT. 27		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	FEB. 21, 1907	49 48 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Seamstress		Lobelia Store		PENNA.		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
D.H. SMITH				MARY SHIPWAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		217-28-099		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
174X IMMEDIATE CAUSE (A)				Uterine Carcinoma		Two ye 7 1/2	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 4, 1955, to October 27, 1955, that I last saw the deceased alive on October 27, 1955, and that death occurred at 2:40 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
J. J. Haffer				Cumberland, Md.		10-29-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 30, 1955		Fairview Christian Cem.		Bedford Co. Penn.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 29, 1955		Walter R. Trout, M.D.		John J. Haffer, Cumberland, Md.			

3019 3PM 17 JUL 28, 78

714 1235

100

PL. CALABRUM, 1811 (25-26)